# Social Return on Investment Study
# Supporting People Programme

## June 2021

Housing Executive

supportingpeople
supporting independence

Supporting Organisations
Enabling Social Change

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# Section 1: Introduction and Context

## 1.1 Introduction

This report sets out a Social Return on Investment (SROI) Study of the Northern Ireland Housing Executive (NIHE) Supporting People (SP) programme for the period April 2018 to October 2020.

## 1.2 Objectives of the Study

The objectives of the study were to:

1. Measure the social value of housing support services funded through the SP Programme in Northern Ireland through engagement with stakeholders and beneficiaries.
2. Quantify the benefits of the SP Programme as a preventative intervention through measuring the social, economic, environmental, and other benefits of the Programme.
3. Evaluate the extent to which SP is meeting objective need, maximising impact, delivering best value for money (encompassing all costs and benefits) and affordability,
4. Inform strategic planning for the SP Programme.

## 1.3 Report Structure

This report structure is set out below, it is framed around the six stages of SROI which are incorporated within Sections 4-6.

- Section 1: Introduction and context for the SP programme
- Section 2: Methodology
- Section 3: Literature & Policy
- Section 4: Establishing Scope & Identifying Stakeholders
- Section 5: Mapping & Evidencing Outcomes
- Section 6: Calculating the SROI
- Section 7: Key Learning
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The report is supplemented by a value map made available to the commissioner which is an excel spreadsheet containing all the calculations necessary to calculate the SROI for the SP programme. The value map is summarised and illustrated throughout the report.

## 1.4 About the Supporting People (SP) Programme

The SP programme is administered by The Northern Ireland Housing Executive (NIHE) on behalf of the Department for Communities (DfC) who allocate the annual budget and retain overall policy and legislative responsibility for SP. The NIHE is the public housing authority for and the largest social housing landlord in Northern Ireland. It is the enforcing authority for those parts of housing orders that involve houses with multiple occupants, houses that are unfit, and housing conditions.

NIHE's mission is: "Working in partnership to ensure that everyone has access to a good affordable home in a safe and healthy community".

NIHE's Vision is that: "Everyone is able to live in an affordable and decent home, appropriate to their needs, in a safe and attractive place".

Launched across the UK in 2003, the SP programme helps vulnerable individuals and families to live independently. Its purpose is to provide housing support services to vulnerable people, to enable them to live as independently as possible in the community. Supporting people in Northern Ireland has three broad objectives.

- Achieve a better quality of life for vulnerable people to live more independently and maintain their tenancies.
- Provide housing support services to prevent problems that can often lead to hospitalisation, institutional care, or homelessness.
- Help to smooth the transition to independent living for those leaving an institutionalised environment.

The SP Programme grant funds 86 delivery partners that provide over 850 housing support services for to up to 19,000 service users across Northern Ireland per annum, with an annual budget of £72.8m (2019/20). Housing related support services help people live independently or move onto more independent living. This can include support to:

- develop domestic/life skills
- develop social skills/behaviour management
- find other accommodation
- establish social contacts and activities
- gain access to other services
- manage finance and benefit claims
- set up and maintain home/tenancy
- maintain the safety and security of the dwelling

The SP programme provides short term accommodation-based support for those people in housing need (e.g., homeless hostels and refuges for victims of domestic violence) and longer-term support via the provision of peripatetic services to enable a person to sustain a home (e.g., in accommodation-based services where the person has a tenancy and housing related support is provided to assist that person to maintain their tenancy). Short term support is also available through a floating support service to assist vulnerable adults with housing related support tasks to help them maintain independence in their own home regardless of their tenure type (typically for up to 2 years duration).

The 2015 DSD Review of SP noted that the Floating Support Model plays a key role in early intervention and prevention and highlighted the potential to extend SP services geographically, particularly across rural areas. Based on these findings, the review recommended that the NIHE should actively progress opportunities to expand the floating support service as a cost-effective way of meeting need.

The SP programme is delivered through a wide range of delivery partners including statutory bodies, housing associations, private sector companies, and voluntary and community organisations. It also integrates with Health, Social Services and Probation to monitor the quality and effectiveness of support services. The SP programme is managed across four thematic areas, Disability & Mental Health, Homelessness, Older People and Young People.

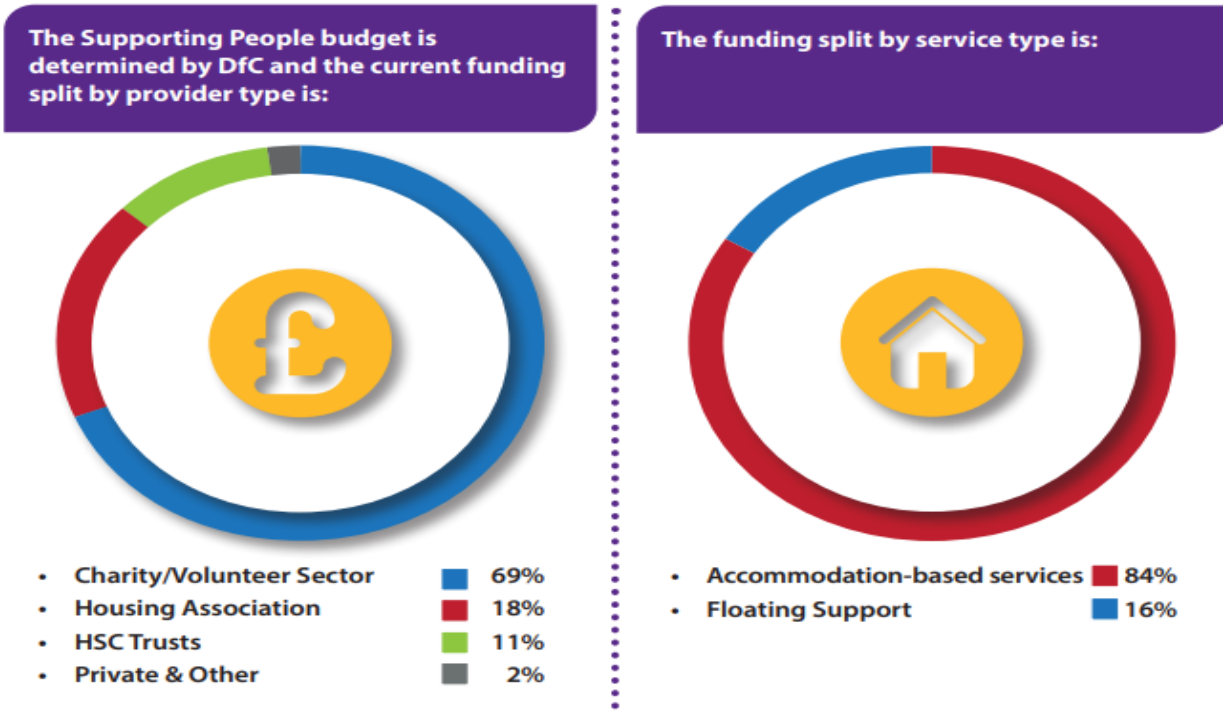



Figure 1: SP funding (Source 2019-20 SP Annual Report)

# Section 2: Methodology

## 2.1 Introduction

In September 2020, S3 Solutions was commissioned by the NIHE to undertake a Social Return on Investment (SROI) study of the SP programme. This section sets out the methodology adopted to deliver the terms of reference for the study, which included the following activity, carried out between October 2020 and April 2021.

## 2.2 Data Collection

To inform the data collection process, 5 co-design workshops were facilitated with 34 SP provider organisations, focussed on the 4 thematic groups of mental health and disability, young people, older people, and homelessness. The workshops were used to shape and design research questions, gain insight to the outcomes of SP for both providers and service users and to inform suitable approaches for engaging with service users. This ensured some ownership of the stakeholder consultation phase for both providers and service users. The workshops were facilitated via zoom in November 2020-December 2020.

Following the feedback from the co-design workshops, a mixed method approach was used for data collection, capturing both quantitative and qualitative data. This included:

- A web-based survey capturing 40 responses from Supporting People Providers (47% response rate). This represents a statistically valid sample.
- A web-based survey capturing 391 responses from Supporting People service users (2% response rate). An overview of the demographic profile of respondents is provided in Appendix 4.[1]
- Quantitative assessment of outcomes reported by providers using the Supporting People Outcomes System (SP OUTCOMES SYSTEM), managed by NIHE. There are a total of 11 outcome indicators, seven of which are relevant to all thematic groups/service types. (Full copy of Outcomes Framework available in Appendix 1)
- 15 semi structured telephone and web-based interviews with key stakeholder organisations including Health and Social Care Trust, Department of Health, Probation Board Northern Ireland, Youth Justice Agency, Department for Communities and Northern Ireland Housing Executive.

[1] The survey was issued in December 2020 and closed in February 2021. It was sent to NIHE for SP Provider Organisations to distribute among service users.

The research was completed between September 2020 and April 2021. All engagements were facilitated online or by phone due to the COVID-19 pandemic. To enable feedback from service users who could not access the online survey, a PDF version of the survey was sent to providers by email and completed in hard copy by service users. Providers returned hard copies of these surveys to S3 Solutions for data input.

## 2.3 Data Analysis

Qualitative data analysis was conducted using thematic approaches[2]. Categories were developed, coded, and reduced. Survey data, researchers' observations and thematic data from interviews was cross referenced in order to identify emergent themes. Participant sampling and data collection continued until no new conceptual insights were generated and the research team felt they had gathered repeated evidence for the thematic analysis, thus reaching theoretical saturation.

## 2.4 Limitations for Data Collection & Analysis

Despite adherence to the SROI methodology and efforts throughout the study to increase the reliability of findings, the SROI analysis of SP includes some limitations that may impact the robustness of findings.

It lacks independent verification from professionals of changes in the outcome areas of health and wellbeing. Given the retrospective nature of the study, no baselines were available for any of the stakeholder groups in the monetised outcome areas prior to the SP intervention. The study did not have a control group to validate the attribution rate which may have reduced our ability to clearly establish how much of the outcome was due to other interventions.

The study is largely reliant on the outcomes data reported by providers through the SP Outcomes System. This information is self-reported and is not quality assured in depth beyond system automation of data. While we were able to identify, through the co-production workshops with a sample of providers, that some used evidence-based outcome measurement tools[3], there is no standardised tool used by all SP providers. Despite efforts to enhance the overall validity and reliability of outcomes data through the distribution of web-based surveys to both providers and service users as well as qualitative focus groups and interviews with stakeholders and providers, this represents a limitation of the research.

[2] *Lewis-Beck, M. S., Bryman, A. & Liao, T. F. (Eds.) (2004). The SAGE encyclopaedia of social science research methods (Vols. 1-3). Thousand Oaks, CA: SAGE Publications*

[3] Outcome Star, Outcome Wheel, I-Planit

## 2.5 Social Return on Investment (SROI)

Measuring the tangible costs and outputs of a service or activity is relatively straightforward, however quantifying the wider social, economic, and environmental outcomes that a service or activity is delivering is more challenging. SROI is an approach to understanding and managing the value of these social, economic, and environmental outcomes. It is based on a set of principles that are applied within a framework. SROI is similar to cost-benefit analysis, in that it assigns a monetary value to outcomes, both positive and negative, thus enabling different activities to be compared in monetary terms. It is based around the seven principles in Table 1.

| Principle | Details |
|---|---|
| **1.Involve stakeholders** | Understand the way in which the organisation creates change through a dialogue with stakeholders |
| **2.Understand what changes** | Acknowledge and articulate all the values, objectives, and stakeholders of the organisation before agreeing which aspects of the organisation are to be included in the scope |
| **3.Value what matters** | Use financial proxies for indicators to include the values of those excluded from markets in same terms as used in markets |
| **4.Only include what is material** | Articulate clearly how activities create change and evaluate this through the evidence gathered |
| **5.Do not over-claim** | Make comparisons of performance and impact using appropriate benchmarks, targets, and external standards. |
| **6.Be transparent** | Demonstrate the basis on which the findings may be considered accurate and honest and that they will be reported to and discussed with stakeholders |
| **7.Verification** | Ensure appropriate independent verification of the account |

Table 1: Principles of SROI

## 2.6 Stages of SROI

This SROI analysis is grounded in transparency and is based on the six stages of SROI evaluation as per table 2 which also highlights the sections of the report where each stage is addressed.

| Stage | Details |
|---|---|
| **Establishing scope and stakeholders**<br><br>Section 4 | It is important to have clear boundaries about what your SROI analysis will cover, who will be involved in the process, and how. |
| **Mapping outcomes.**<br><br>Section 5 | Through engaging with your stakeholders, you will develop an impact map, or theory of change, which shows the relationship between inputs, outputs, and outcomes. |
| **Evidencing outcomes and giving them a value**<br><br>Sections 5 & 6 | This stage involves finding data to show whether outcomes have happened and then valuing them |
| **Establishing impact**<br><br>Section 6 | Having collected evidence on outcomes and monetised them, those aspects of change that would have happened anyway or are a result of other factors are eliminated from consideration. |
| **Calculating the SROI** | This stage involves adding up all the benefits, subtracting any negatives, and comparing the result to the investment.<br>This is also where the sensitivity of the results can be tested. |
| **Reporting, using, and embedding**<br><br>Section 6 | Easily forgotten, this vital last step involves sharing findings with stakeholders and responding to them, embedding good outcomes processes, and verifying the report |

Table 2: Stages of SROI

# Section 3: Literature & Policy

## 3.1 Introduction

This section sets out a policy and literature review relative to the SP programme. We consider previous research, evaluation, and cost benefit analysis on housing related interventions as well as the alignment of SP with current and emerging policy and strategy, thus setting the current SROI study, and the SP programme in context.

## 3.2 Legislative Framework for SP

The SP programme was launched under the Labour Government in April 2003. The programme brought together several funding streams, including support provided through the Housing Benefit system, into a single grant for local authorities to fund a variety of services aimed at helping vulnerable people live independently. The initial investment is estimated at £1.8billion[4]. In Northern Ireland, SP is the policy and funding framework for housing support services. The programme was introduced in April 2003 under the Housing Support Services (2002 Order) (Commencement) Order (Northern Ireland) 2003 and the Housing Support Services Regulations (Northern Ireland) 2003[5] with an initial annual budget of £46 million.

DfC allocates the annual budget for the SP programme and has overarching policy and legislative responsibility for SP, whilst the NIHE is responsible for approving and making final decisions on the commissioning of housing support services that meet strategic need identified by a Strategic Advisory Board - a partnership of local housing, social care, health, and probation statutory services that plays a key role in advising and approving SP services. As of 2019/2020, SP grant funds 86 delivery partners that provide over 850 housing support services for to up to 19,000 service users across Northern Ireland. The budget for the SP Programme in Northern Ireland increased from £46 million in 2003/04, to £72.8 million in 2014 (since then the baseline budget has remained static at £72.8 million)[6].

At its inception, SP was created through the amalgamation of several funds which were supporting around 650 of the current 850 services at that time. These 650 'legacy' services were all accommodation-based services and reflected the range and diversity of client groups that are included in the current programme.

[4] *House of Commons Library: The Supporting People programme RESEARCH PAPER 12/40 16 (July 2012)*
[5] *https://www.communities-ni.gov.uk/topics/housing/supporting-people-and-homelessness*
[6,7] *Supporting People Plan 2019-20 & Strategic Intent 2020-22*

The funding levels in place in 2003 for these legacy services were largely carried forward and maintained[7]. Typically, grant funding agreements are renewed annually with service providers and usually at the same rate as previous years[8].

## 3.3 Policy Context: Draft Programme for Government

The NI Executive is developing a new strategic, Outcomes-based Programme for Government (PfG) which aims to deliver real, lasting, and positive change in people's lives. The new PfG will replace its predecessor (2016-2021) which comprised 14 outcomes and 42 indicators. The new draft PfG proposes a framework of nine Outcomes – these are statements of societal wellbeing which, taken together, are intended to capture the range of things that experience, and research suggest matter most to people[9]. The nine outcomes are set out in the image below.


**Figure 2: PfG Draft Outcomes Framework**

[8] *With the exception of 2017/18, when a 5% reduction was applied to accommodation-based services only (Floating Support, SNMA and new schemes were protected). At time of writing, providers had not received an annual funding uplift since 2007.*

[9] *www.northernireland.gov.uk/sites/default/files/consultations/newnigov/pfg-draft-outcomes-framework-consultation.pdf*

Each outcome is supported by a range of 'priority areas', several of which align with the SP programme in NI (based on findings in this report), this is captured in table 3 below:

| Outcome | Priority Area | Description |
|---|---|---|
| We have an equal and inclusive society where everyone is valued and treated with respect | Inclusion and Tackling Disadvantage | Tackling the issues that lead to inequality and disadvantage in terms of welfare and poverty and providing support where it is needed in both urban and rural communities. |
| We all enjoy long, healthy active lives | Access to Health | Taking forward health and social care reform to ensure we can deliver safe, high quality services to meet the challenges of the future and provide the right services where they are needed. |
| | Mental Health and Wellbeing | Promoting positive attitudes towards mental health and wellbeing. Ensuring access to a comprehensive array of early intervention and healthcare services to address mental health issues where they present. |
| Everyone can reach their potential | Capability and Resilience | Supporting personal development opportunities for everyone and building confidence and capacity. |
| Everyone feels safe – we all respect the law and each other | Address Harm and Vulnerability | Supporting and putting protections in place for those who are vulnerable, meeting the needs of those who have experienced serious crime, including the complex needs of children, and delivering for victims and survivors. |
| | Early Intervention and Rehabilitation | Addressing offensive behaviours' and tackling organized crime, supporting rehabilitation, intervening early, meeting the often-complex needs of both children and adults throughout the justice system |
| We have a caring society that supports people throughout their lives | Disability | Improving the quality of life for those of us with disabilities, empowering people to have more influence over their own lives and providing opportunities to participate in decisions that affect them |

| Outcome | Priority Area | Description |
|---|---|---|
| We have a caring society that supports people throughout their lives | Housing | Tackling homelessness. Facilitating and supporting housing associations, provision and maintenance of appropriate social housing, investment in new social and affordable homes |
| | Inclusion and Tackling Disadvantage | Supporting people to build a route out of poverty, administering an effective social security / benefits system to those who need it, tackling the issues that lead to inequality |
| | Mental Health and Wellbeing | Promoting positive mental health and wellbeing, and addressing social issues, risk factors and environmental impacts, such as social isolation and loneliness. Providing access to supportive services and promoting early intervention. |
| People want to live, work, and visit here | Housing | Tackling the issues to ensure everyone has access to good-quality, affordable housing and in promoting an integrated, shared society. |

**Table 3: SP alignment with PfG Outcomes**

The outcomes generated by SP services are described in section 5 of this report. There is a strong correlation between the outcomes generated by SP and the outcomes and priority areas in the new PfG as shown in table 3. The range and depth of outcomes reported by SP service providers and service users is reflective of the complex and multi-faceted nature of the intervention which accounts for 15 different client groups – each of which can face a unique mix of challenges and vulnerabilities.

The table showcases the cross-cutting contribution of the SP programme to the new PfG with a clear concentration on outcomes relating to: healthy lives, feeling safe and a caring society that supports people throughout their lives. This resonates with the original aims and objectives of SP. On reflection, there appears to be a stronger alignment between SP and the nine outcomes in the new PfG than to the 14 outcomes and 42 indicators in the preceding PfG, reinforcing the strategic position of the SP programme.

DfC has policy responsibility for the SP programme and this responsibility is produced within the context of the PfG. DfC undertake a variety of activities and have named responsibility for priority areas across seven of the proposed PfG outcomes. DfC works collaboratively across Government

to achieve these outcomes and commissions its Arm's Length Bodies to support this work (of which the Northern Ireland Housing Executive is one).

The DfC Business Plan 2019/20 sets out an initial draft 'common purpose' of 'Supporting People, Building Communities, Shaping Places' which seeks to capture the multi-faceted purpose and responsibility of the department. The business plan is framed against three key strategic objectives, namely:

- R1. A more confident people living their lives to the full
- R2. Lower levels of economic inactivity and unemployment
- R3. Improved places and engaged communities with better housing

The SP programme sits under R3 and is referenced as contributing to outcomes 8, 9 and 11 of the 2016-2021 PfG which are: **We care for others and we help those in need, we are a shared, welcoming, and confident society that respects diversity, we connect people and opportunities through our infrastructure.**

## 3.4 Northern Ireland Housing Executive & SP

The NIHE vision is: ***Everyone is able to live in an affordable and decent home, appropriate to their needs, in a safe and attractive place.***

The NIHE works to three overarching themes:


The Supporting People programme sits under the 'People' theme. Under these themes, the organisation strives to deliver against four high level outcomes: 1. **Helping people find housing support and solutions; 2. Delivering better homes; 3. Fostering vibrant sustainable communities; and** 4. **Delivering quality public services.**

## 3.5 Strategic and Political Influences on SP

The SP programme has operated through a range of major political and strategic drivers over the past 18 years; this has had implications for how the service(s) have evolved. Some of the key drivers are explored in this section.

### 3.5.1 Health and Social Care

**Transforming Your Care -** a Review of Health and Social Care (HSC) in Northern Ireland was published in December 2011. The review identified twelve key factors for change which, it claimed, should be used to form the future direction of HSC services in Northern Ireland. The twelve principles are:

- Placing the individual at the centre of any model of care by promoting a better outcome for the service user, carer and their family;
- Using Outcomes and quality evidence to shape services;
- Providing the right care in the right place at the right time;
- Population based planning of services;
- A focus on prevention and tackling inequalities;
- Integrated care – working together;
- Promoting independence and personalisation of care;
- Safeguarding the most vulnerable;
- Ensuring sustainability of service provision;
- Realising value for money;
- Maximising the use of technology; and
- Incentivising innovation at a local level.

The report pointed to significant increases in pressure on HSC services resulting from: an ageing population, increases in chronic conditions and financial and management challenges within the health and social care system. A primary tenet of the review was the proposed 'shift left' to ensure care is increasingly provided in the home or as close to home as possible with the needs of individuals prioritised within the design and decision-making process about their own health. Greater collaboration across sectors and increased diversity of service available were also key recommendations.

The **Bamford Review** (2007) had major implications for SP with regard to the housing support service needs of people with learning disabilities or mental health problems and the resettlement of people from long stay hospitals. Several recommendations were significant for SP:

- DSD (now DfC) and housing providers should develop a housing strategy to ensure people with mental health problems and learning disabilities can, where possible, live in the accommodation of their choice, subject to normal financial constraints.
- People with mental health problems or learning disabilities should have the choice to live independently but the use of specialised group housing has a role to play, for example as step-down accommodation after leaving hospital; and
- DSD (now DfC) should ensure participation of people with mental health problems or a learning disability in the planning of housing services.

### 3.5.2 Domestic Violence

SP has been an important driver in supporting strategies designed to tackle domestic violence. In 2005, the Department of Health Social Services and Public Safety published a Domestic Violence Strategy, *Tackling Violence at Home: A Strategy for Addressing Domestic Violence and Abuse in Northern Ireland.* Housing services are a major resource for refuge accommodation and outreach services, and this is reflected in the investment of SP in Women's Aid organisations across NI.

Many households that experience domestic violence continue to require housing-related support, to either allow them to remain safely in their own homes or to help if they need to move (SP funding follows the person). The subsequent seven year *Stopping Domestic and Sexual Violence and Abuse Strategy* was published jointly by the Department of Health (DoH) and the Department of Justice (DoJ) in March 2016.

### 3.5.3 Disability & Mental Health

The 2012 *Physical and Sensory Disability Strategy and Action Plan* was extended to 2020 and will be succeeded by a new Disability Strategy in 2021. A key priority of the 2012 strategy was to plan for the provision of more effective services to support independent living options where the person would retain choice and control.

The Disability Rights Commission has defined independent living as "*all disabled people having the same choice, control and freedom as any other citizen at home, at work and as members of the community. This does not necessarily mean disabled people 'doing everything for themselves' but that any practical assistance people need should be based on their own choices and aspirations."*

This definition has enabled SP providers to be more innovative and flexible in supporting people with disabilities including the use of assistive technology to assist independent living. Information can be crucial to feeling empowered and being independent and is critical for social inclusion. The 2012 strategy points to the importance of information and advocacy for people with a disability. However, information of itself is not enough for all disabled people: getting advice and advocacy in order to use it to best effect is needed by many.

SP services facilitate access to information at the right time which assists people stay independent and in control of their lives. Outcomes in relation to access to benefits, sustaining tenancies and independent living discussed in Section 5 of this report is testament to the impact of SP services in underpinning the fundamental right to independent living for people with a disability.

The DoH's 2011 Regional Strategy "*Improving Dementia Services in Northern Ireland*" reflects the importance of supported housing models for people with this condition.

*"For people with dementia who are no longer able to live independently within their own home, supported housing offers a viable alternative to residential care. A key benefit for the person is that they continue to live independently within a safe and secure environment, with care and support available from a dedicated staff over a 24-hour period. The social and built environment is designed to compensate for the person's disability, to promote orientation and enhance the person's feelings of well-being".*

For many people, a diagnosis of dementia can mean social exclusion. Supported housing schemes funded by SP aim to reduce the stigma attached to a diagnosis of dementia through a community-based model which offers the person their own tenancy and promotes the person's experience through involvement in routine daily living activities. The strategy emphasises working in partnership with families and on building and maintaining links with the local community, fostering a more positive public perception of dementia.

### 3.5.4 Homelessness

The Northern Ireland Housing Executive is the body responsible for dealing with homeless in NI. The Housing (Amendment) Act (Northern Ireland) 2010 placed a legislative duty on NIHE to formulate and publish a Homelessness Strategy.

The Homelessness Strategy published in April 2017 provides strategic direction on how NIHE and relevant partners will address homelessness from April 2017 to March 2022. The strategy vision is: 'Ending Homelessness Together'.

The strategy identified three key outcomes: *we have support that prevents us from becoming homeless*; *we live in suitable homes*; *we have the support we require to access and/or sustain a home*. The outcomes are framed under the Draft PfG Outcome 'We care for others and help those in need'.

This Strategy aims to prevent homelessness, ensure that households experiencing homelessness are supported to find suitable accommodation and support solutions as quickly as possible and ensure a cross departmental and inter agency approach to ending homelessness.

## 3.6 Supporting People Reviews and Evaluations

The changing strategic and political landscape has necessitated considerable evolution and growth in SP funded services over the past 18 years. This has helped shape the introduction of new services and in some cases the reconfiguration of legacy services. Around 200 new services have been funded by SP since its inception, 70 of which are Floating Support services and 130 are accommodation based – the majority of these were linked to recommendations from the Bamford Review[10].

The SP programme (or its individual components) has been subject to a range of reviews and evaluation including (not exhaustive):

- *Evaluation of Accommodation Based Services Funded by Supporting People* Final Report October 2015
- DSD Review of the Supporting People Programme (2015)
- *The Financial Benefits of the Supporting People Programme in Northern Ireland A Report for NICVA* 2015
- *Strategic Needs Assessment for the Supporting People Programme: A Policy Statement* (January 2017)

Each of the evaluations and reviews offered recommendations about new approaches, services, processes, or methodologies to be adopted by the SP programme. The Department for Communities led a review of the Supporting People programme which was published in November 2015. This review recommended the introduction of a new strategic, intelligence-led approach to needs assessment and competitive selection, both of which could shape how services funded by Supporting People are commissioned in the future.

In Northern Ireland, the NICVA review[11] carried out in 2015 was to date the main attempt to assess the cost benefit or value for money of the SP programme. This review, whilst adopting some Social Return on Investment methodologies and principles, was framed around cost savings rather than social value generated. It majored on the "avoidance of costs" in residential care, health, and justice and concluded that for every £1 spent on SP services, it saves the public purse £1.90. This in itself is a useful finding, yet the report did not place any value on the outcomes accrued by service users, which is at the heart of Supporting People.

[10] https://www.healthni.gov.uk/sites/default/files/publications/dhssps/Strategic%20Framework%20for%20Adult%20Mental%20Health%20Report.pdf

[11] https://www.nicva.org/sites/default/files/d7content/attachments-resources/web_report.pdf

This SROI study seeks to measure and calculate the total value generated for all stakeholders including service users. The use of SROI in assessing the social impact of housing related interventions is common. There are a range of studies of note:

- *The efficiency and effectiveness of the housing first support service piloted by DePaul in Belfast, funded by Supporting People: An SROI Evaluation* found that for every £1 invested in the Housing First Service in Belfast in 2014, there was a social value created of £15.06.
- National studies of effectiveness in the delivery of housing support services and value for money (VFM) were commissioned across England, Scotland, and Wales between 2003-2009. These studies were based on estimates of the costs avoided by other programmes as a result of the existence of the Supporting People programme. The results of the studies indicate savings of: £1.10 for every £1 spent on Supporting People in Scotland (2007 study); £1.68 per £1 of expenditure in Wales (2006 study) and £2.12 for every £1 spent in England (2009 study). The data were considered to be sufficiently robust for use by the Audit Commission in England and the Welsh Audit Office.

The validity of SROI as a method to evaluate the SP programme is reinforced by the involvement of housing associations in driving the concept of social value in the third sector. The Social Value Bank[12] which was developed by the Housing Association Charitable Trust (HACT) is the largest bank of methodologically consistent and robust social values produced, and has been a useful source for many of our proxies in this study.

## 3.7 Summary

Our review of the strategic positioning of the SP programme evidences the cross-cutting contribution of the SP programme to the new PfG with a clear concentration on outcomes relating to: healthy lives, feeling safe and a caring society that supports people throughout their lives. There is also clear strategic alignment with prevailing policy and strategy in health & social care, housing, disability, mental health, domestic violence, and homelessness.

The use of SROI in evaluating the social impact of housing related interventions is increasing in incidence with many of the studies focussing on savings accrued by health, housing, and justice government departments. Measuring and valuing "soft" outcomes for service users such as independence and well-being has been challenging for research and literature; however, the advent of the Social Value Bank by HACT has provided a valuable resource for sourcing accredited and robust financial proxies to value same outcomes.

[12] *https://www.hact.org.uk/calculating-your-social-value*

# Section 4: Establishing Scope & Identifying Stakeholders

## 4.1 Introduction

This section will establish the scope of the SROI study and identify the stakeholders who are most material[13] to the analysis.

## 4.2 Scope of Study

The scope of the study determines the activities and duration to be included in the SROI study and is an important stage in the process. It must align with the other stages of SROI and be reflective of available data and what can be collated through the stakeholder engagement. Overextending on scope can result in a lack of robust data to evidence outcomes while being too rigid in scope can lead to the activities and services being undervalued.

This study is an evaluation, not a forecast. The scope for the SP SROI study was agreed with the Project Advisory Group[14] and covers the financial years, 2018-2019, 2019-2020 and the first two quarters of 2020-2021. The decision to use April 2018 as the starting point was predicated around the fact that SP began to collect outcomes data at this point. The scope includes the 19,000 people that SP supports each year through grant funding for over 850 housing support services delivered by 86 service providers across the public, voluntary and community, and private sectors.

The scope also includes the four thematic SP groups and 15 primary client groups which provide further definition on the vulnerability and issues presenting. A breakdown of the number of organisations and services per client group who provided support during the scope of the study is presented in Table 4 overleaf.

[13] *Materiality in SROI relates to the importance/significance of the change experienced by an individual or organisation resulting from a service or intervention.*
[14] *Members from across relevant departments in the NIHE*

| Primary Client Group | Organisations | Services |
|---|---|---|
| Frail Elderly | 6 | 17 |
| Homeless Families and Support Needs | 22 | 62 |
| Offenders or people at risk of offending | 8 | 12 |
| Older people with mental health problems/dementia | 10 | 28 |
| Older people with support needs | 30 | 389 |
| People with physical or sensory disability | 11 | 26 |
| People with alcohol problems | 14 | 24 |
| People with drug problems | 2 | 2 |
| People with learning disabilities | 14 | 119 |
| People with mental health problems | 27 | 62 |
| Single Homeless with Support Needs | 39 | 80 |
| Traveller | 2 | 2 |
| Women at risk of domestic violence | 18 | 44 |
| Young people | 19 | 58 |

**Table 4: Scope of SP SROI Study**

## 4.3 Stakeholder Analysis

Understanding how a service or organisation creates change is central to the SROI stakeholder analysis. In SROI, stakeholders are defined as individuals, groups or organisations that are impacted (positively or negatively) by an activity or service. The SROI study through a theory of change and impact map must articulate clearly how and to what extent the SP activities create change for stakeholders.

The SP outcomes framework sets out a range of high-level programme outcomes aligned to outcome indicators and service level outcome measures to capture the difference that its intervention is making to the lives of service users. It does not explore the change created for stakeholders other than the service users, hence our stakeholder analysis was cognisant of the need to capture the possible impacts accrued by all stakeholders as a result of the SP programme.

The stakeholder analysis illustrated in Table 5 was informed by the co-design workshops and agreed in consultation with the Project Advisory Group for the SROI study. It sets out the desired outcomes for those stakeholders who were deemed to be material to this study.

| Stakeholder | Desired Outcomes |
|---|---|
| Service Users | Improved Economic Well-Being, Increased Independence<br>Improved Health & Well-Being, Improved Safety & Security<br>Reduced Isolation |
| Service Users Families | Improved Family Relationships, Stronger Family Identity |
| Service Providers | Improved organisational/service sustainability<br>Improved quality of service<br>Improved diversity of services<br>Improved reputation in the sector |
| Department for Communities | More cohesive & resilient communities |
| Department for Health | Reduced health and social care costs associated with less adverse events requiring treatment for service users |
| Department of Justice (Probation Board NI, Police Service Northern Ireland, Youth Justice Agency) | Reduced numbers in the Justice System (Prisons, Probation)<br>Reduced anti-social behaviour<br>Reduced policing costs |
| NIHE | Increased occupancy<br>Reduced tenancy failure costs<br>Reduced homelessness |

**Table 5: SP Programme Stakeholder Analysis**

# Section 5: Evidencing & Valuing Outcomes

## 5.1 Introduction

With the stakeholder analysis and desired outcomes set out in Section 4, this section explores the available data to evidence the extent to which these outcomes were achieved for the designated stakeholders within the period of the scope of the study. Case studies are included for a sample of service users.

## 5.2 Service Users

The study accessed records of outcomes data reported to SP by providers. There are a total of eleven outcome indicators, seven of which are relevant to all thematic groups/service types (see Table 6). Each of the outcome indicators are aligned to the five high level outcomes of SP and the majority of services report on at least one indicator and no more than two indicators for each of the five high level areas. Crisis Accommodation Services (Crash) report on three specific indicators that other services are not required to report on. Similarly, Crash services do not report on the seven indicators associated with the other Thematic Groups. (Full copy of Outcomes Framework available in appendix 1).

The outcomes are collected by providers using their own collection tools/systems. Short term services report on a quarterly basis on clients who have departed the service during that quarter and long-term services report annually on all existing clients, including those who have departed the service.

Outcomes Measurement was introduced to the Supporting People programme in April 2018 as a way for providers to report on outcomes being achieved by clients within their services. The data is collected at client level and reported to Supporting People at service level. The outcomes which providers report on were designed in consultation with the provider sector and are linked to the Draft Programme for Government Outcomes.

In the context of this SROI study, the data reported by providers using the SP outcomes system is used to evidence and value the achievement of outcomes for service users. It is to these figures that a financial proxy has been assigned. The study also captured 391 responses from SP service users and 40 responses from SP Providers, which are used to complement existing data and validate findings. This section will provide further explanation and definition of the outcomes evidenced with supporting verbatim quotations offered to reinforce the difference that SP is making to the lives of the primary client groups.

| High Level SP Outcome | SP Services - Indicators |
|---|---|
| Improved economic wellbeing | 1a. Service users supported to access welfare benefits<br><br>1b. Service users supported to gain employment (paid or voluntary) and/or enhance skills / education |
| Increased number of people living independently | 2a. Service users supported to remain in own home (LONG TERM SERVICES ONLY)<br><br>2b. Service users supported to achieve independent living (SHORT TERM SERVICES ONLY)<br><br>2c. Number of service users supported to move into alternative temporary living arrangements (CRISIS ACCOMMODATION SERVICES ONLY)<br><br>2d. Service users supported to maintain their tenancy as a result of floating support<br>(FLOATING SUPPORT SERVICES ONLY) |
| Being healthy | 3a. Service users supported to manage their physical / mental health<br><br>3b. Number of service users supported to access healthcare (CRISIS ACCOMMODATION SERVICES ONLY) |
| Living in safety and security | 4a. Number of service users who have been supported to feel secure in own home/tenancy<br><br>4b. Number of service users who have been supported to feel secure and protected<br>(CRISIS ACCOMMODATION SERVICES ONLY) |
| Achieving and making a positive contribution | 5a. Service users supported to contribute to wider society and enhance social networks |

**Table 6: SP Outcomes & Indicators**

A breakdown of the number of service users achieving outcomes is provided in Table 7 and Table 8 provides a further breakdown of achievement of outcomes per each of the primary client groups. For the purposes of this SROI study, the eleven outcome indicators have been reduced to nine; maintaining tenancy and remaining in own home have been grouped with independent living and subsequently valued as one outcome.

| Outcome | Total positive change recorded | Total service users accessing support | % |
|---|---|---|---|
| Welfare benefits (in receipt of all the relevant benefits) | 25,164 | 27,771 | 91% |
| Gain Employment (paid or voluntary) and/or desired training/education | 9,085 | 12,934 | 70% |
| Improved independent living (including maintain tenancy, remain in own home) | 31,687 | 35,579 | 89% |
| Manage their Physical/ Mental Health | 27,365 | 29,755 | 92% |
| Secure in their Home/Tenancy | 33,153 | 34,908 | 95% |
| Contribute to Society and Social Networks | 27,454 | 31,178 | 88% |
| Access Alternative Temporary Living Arrangements (crisis) | 622 | 4,404 | 14% |
| Access Healthcare (crisis) | 1,178 | 4,351 | 27% |
| Secure & Protected (crisis | 394 | 394 | 100% |

**Table 7: Service User Outcomes delivered by Supporting People (reported via SP Outcomes System)**

| | Welfare Benefits | | | Employment | | | Remain in own Home | | | Independent Living | | | Maintain Tenancy | | | Physical & Mental Health | | | Safe & Secure | | | Society & Social Networks | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | A | Total | % | A | Total | % | A | Total | % | A | Total | % | A | Total | % | A | Total | % | A | Total | % | A | Total | % |
| Frail Elderly | 201 | 205 | 98 | 93 | 95 | 98 | 332 | 353 | 94 | | | | | | | 311 | 311 | 100 | 351 | 351 | 100 | 298 | 304 | 98 |
| Homeless Families with Support Needs | 2,011 | 2,116 | 95 | 495 | 648 | 76 | | | | 725 | 800 | 91 | 1,188 | 1,243 | 96 | 1,486 | 1,605 | 93 | 1,656 | 1,806 | 92 | 1,317 | 1,428 | 92 |
| Offenders/people at risk of offending | 647 | 678 | 95 | 149 | 233 | 64 | | | | 110 | 155 | 71 | 280 | 314 | 89 | 442 | 452 | 98 | 345 | 466 | 74 | 416 | 442 | 94 |
| Older people with mental health problems | 367 | 379 | 97 | 78 | 86 | 91 | 426 | 566 | 75 | | | | 22 | 27 | 81 | 448 | 460 | 97 | 433 | 445 | 97 | 445 | 470 | 95 |
| Older people with support needs | 6,958 | 8,201 | 85 | 1,159 | 1,601 | 72 | 12,733 | 13,681 | 93 | | | | 709 | 927 | 76 | 7,962 | 8,738 | 91 | 13,332 | 13,609 | 98 | 9,445 | 10,994 | 86 |
| People with physical and sensory disability | 627 | 704 | 89 | 87 | 115 | 76 | 163 | 163 | 100 | | | | 667 | 715 | 93 | 408 | 451 | 90 | 467 | 505 | 92 | 505 | 569 | 89 |
| People with alcohol problems | 1,371 | 1,483 | 92 | 1,025 | 1,204 | 85 | | | | 1,050 | 1,227 | 86 | 89 | 101 | 88 | 1,638 | 1,751 | 94 | 1,341 | 1,453 | 92 | 1,321 | 1,459 | 91 |
| People with drug problems | 80 | 88 | 91 | 14 | 21 | 67 | | | | | | | 94 | 97 | 97 | 85 | 105 | 81 | 81 | 93 | 87 | 63 | 71 | 89 |
| People with learning disabilities | 1,651 | 1,663 | 99 | 1,446 | 1,522 | 95 | 1,838 | 1,870 | 98 | | | | 53 | 61 | 87 | 1,856 | 1,861 | 100 | 1,839 | 1,872 | 98 | 1,840 | 1,865 | 99 |
| people with mental health problems | 1,580 | 1,784 | 89 | 650 | 818 | 79 | 1,261 | 1,298 | 97 | 101 | 111 | 91 | 965 | 978 | 99 | 3,069 | 3,082 | 100 | 2,726 | 2,757 | 99 | 2,708 | 2,807 | 96 |
| Single Homeless with support needs | 5,778 | 6,313 | 92 | 1,219 | 3,261 | 37 | 23 | 23 | 100 | 2,038 | 3,441 | 59 | 1,367 | 1,483 | 92 | 5,046 | 5,849 | 86 | 4,301 | 4,899 | 88 | 3,923 | 4,910 | 80 |
| Traveller | 61 | 63 | 97 | 2 | 2 | 100 | | | | | | | 39 | 45 | 87 | 19 | 22 | 86 | 4 | 4 | 100 | 18 | 20 | 90 |
| Women at risk of domestic violence | 2,605 | 2,795 | 93 | 1,912 | 2,352 | 81 | | | | 659 | 771 | 85 | 3,694 | 3,911 | 94 | 3,417 | 3,772 | 91 | 5,128 | 5,405 | 95 | 3,904 | 4,480 | 87 |
| Young people | 1,227 | 1,299 | 94 | 756 | 976 | 77 | | | | 303 | 358 | 85 | 758 | 860 | 88 | 1,178 | 1,296 | 91 | 1,149 | 1,243 | 92 | 1,251 | 1,359 | 92 |
| | **25,164** | **27,771** | **91** | **9,085** | **12,934** | **70** | **16,776** | **17,954** | **93** | **4,986** | **6,863** | **73** | **9,925** | **10,762** | **92** | **27,365** | **29,755** | **92** | **33,153** | **34,908** | **95** | **27,454** | **31,178** | **88** |

A = Achieved

**Table 8: Outcomes per primary client group**

### 5.2.1 Improved economic well-being

From the period 2018 to the first two quarters of 2020/21, SP providers reported that they supported 27,771 service users (see table 7) to apply for welfare benefits and of those, 25,164 service users (91% of total) received such benefits. During the same period, SP providers reported that they successfully supported 9,085 (70%) out of 12,934 service users to gain employment (paid or voluntary) and/or desired training/education including attendance at day centres and classes.

100% of providers who responded to the SP provider survey identified that their service delivered improved economic wellbeing for their client group and 70% identified that their service delivered improved employability for their client group.

Furthermore, 69% of service users who responded to the survey indicated that they were supported to access benefits and when asked to explain the difference that this support had made to their life, many noted that the SP service helped them with debt management, paying bills including organizing essential payments for food, electricity, heating, and other necessities as well as securing employment.

*"The support has helped me secure maximum benefits, get registered with a GP, and work towards getting social housing accommodation."* (Service User Feedback)

*"It has made a big difference as I was in debt and owed lots of money and I got the help to get this sorted. My home was also very cluttered, and I got help to get rid of a lot of things. I also got help to move to a better flat after I got burgled and now I am much safer and much more independent."* (Service User Feedback)

*"I have received support with housing renovations and having the house cleared and cleaned throughout, I also have had help with managing my finances and arranging for utilities to be paid. Support has made a big difference."* (Service User Feedback)

*"My pension was frozen, and I got support to restart it without this support I had no income"* (Service User Feedback)

*"I have left Muckamore and have a part time job with my own flat."* (Service User Feedback)

### 5.2.2 Improved independent living

From the period 2018 to the first two quarters of 2020/21, SP providers across seven primary groups (see table 8) reported that they successfully supported 16,776 service users out of 17,954 to remain in their own home, a total of 93%. During the same period, SP providers across seven primary client groups reported that they successfully supported 4,986 service users out of 6,863 to achieve independent living while SP providers across 14 primary client groups reported that they supported 9,925 service users out of 10,762 (92%) to successfully maintain their tenancy (92%).

Although providers report the above outcome indicators separately, to avoid double counting and duplication, as part of this study each are measured as indicators of improved independent living. We have assigned a financial proxy to that outcome, i.e., a total of 31,687 service users out of 35,579 have successfully achieved independent living as a result of SP (89%) (see Table 7).

100% of providers who responded to the SP provider survey identified that their service improved their client group's capacity to live independently and 77% of service users who responded to the survey indicated that they were supported to improve their ability to live independently. 63% of service users who responded to the survey indicated that they were supported with tenancy related issues, 39% indicated they were supported with their housing rights while 53% indicated that they were supported to secure long-term accommodation.

When asked to explain the difference the support had made to their life, service users who responded to the survey noted that the SP service helped them to 'stand on their own two feet', and improved their confidence to manage and maintain their home as well as deal with any issues they face.

*"Changed my life to start again on my own two feet"* (Service User Feedback)

*"I am now moving to a new flat with a positive attitude to living independently" (*Service User Feedback)

*"It has saved my life. The hostel has put a roof over my head when no one else would. Support workers are extremely effective"* (Service User Feedback)

*"Got my own flat, supported to attend appointments for housing, benefits, mental health, medical etc. Supported to manage my finances. More independent especially since moving into my flat and I can deal with more issues myself."* (Service User Feedback)

*My support worker has given me support to sort out my benefits and bank as I was in a nursing home and came home and did not know where anything was. She also set up a grocery account so carers can lift my weekly shopping or other essential items. My support worker arranged an eye test of which I hadn't had one in a long time and am now waiting on a further appointment from macular clinic, my support worker also referred me to the sensory disability team for help, advice, and any aids. This support has made a huge difference to my life and assisted me to live independently whilst giving me reassurance.* (Service User Feedback)

*"I was referred for support as I was looking to move into a more permanent home as my family home had to be sold, I was on the housing list for a very long time with no communication. My support worker assisted me to communicate with social housing and I have been able to secure a permanent home in sheltered accommodation whilst supported to move home, change address, update utilities and source housing benefit and other health supports. Having this support has been life changing for me and I am now able to live my life more independently as I am living in a small village and am able to access local shops myself whilst not having to rely on others, I feel more safe and secure in my home due to the type of secure accommodation I live in."* (Service User Feedback)

### 5.2.3 Improved Health & Well-Being

For the period of the scope of this study, SP providers across all primary client groups (see table 8) reported that they successfully supported 27,365 service users out of 29,755 to access primary health care such as mental health services, social services and counselling/advocacy services, which subsequently improved their mental and physical health.

100% of providers who responded to the survey identified that their service delivered improved mental health and wellbeing for their client group and 80% identified that their service delivered improved physical health for their client group. Furthermore, 76% of service users who responded to the survey indicated that they were supported to improve their physical wellbeing while 72% indicated that they were supported to improve their mental wellbeing.

When asked to explain the difference the support had made to their life, service users who responded to the survey noted that the SP service helped them to access and attend medical appointments, obtain appropriate medication, and manage or alleviate their addictions. Service users also noted that they were supported to cope with bereavement and felt less stressed as a result of having 'someone to talk to' for advice and guidance. Supporting quotations are provided overleaf.

*"I feel the Simon community has changed my life, the support I have been given to overcome my addictions, support with my housing and benefits and just support for a chat with staff has been things I will never forget."*

*"The support I have received from Larne Simon Community has been overwhelming, the support I have been given has helped combat addictions, a proper secure roof, am forever grateful for this."*

*"To be able to sleep in a bed of my own, in a room of my own has been comforting as I had spent time on friends and families' sofas. To have staff present to support your needs when you struggle with mental health and addiction goes way beyond useful."*

*"At this stage I am not ready to have my own place. I am not long out of prison, but the staff have helped me find my feet and have given me great support especially with getting my medication organised. I am trying to get my life together again and I know I can do it with the support of staff. I have the odd rough day, but this place is like a family, and we all help each other."*

*"I live with my brother, and we never had any support in the home due to not being in contact with anyone. Since having the support of my support worker, we were able to have heating restored in the home and oil delivered regularly. I never had an eye test and my support worker was able to arrange a home visit with the Opticians for an eye test and I needed new reading glasses of which has made a huge difference to me, my support worker also arranged a home visit with the Chiropodist I was nearly crippled with pain in my feet due to corns, this has now been seen to and I am able to walk again with support I was able to buy new supporting shoes. My support worker has provided me with a phone and Tablet of which I knew nothing about, and they are things I wouldn't of knew about only for her and is helping me use these devices. I never had a pension or any money of my own, with support I was able to claim pension credit of which I got a huge back payment and now have money going into my own bank account of which I didn't have either. During the lock downs I received support to access local shops and transport. Having support has changed my life, it is great having someone there to guide me and to give me advice when needed as I did not have anyone else to talk to."* (Service User Feedback)

### 5.2.4 Improved Safety & Security

For the period of the scope of this study, SP providers across all primary client groups (see table 8) reported that they successfully supported 33,153 service users out of 34,908 to feel safe and secure in their own home/tenancy. This includes supporting service users with repairs/adaptations, assistive technology, warden services, reassurance via floating support, getting a service user a place in a temporary hostel, or assisting in getting a service user a tenancy in sheltered housing.

60% of service users who responded to the survey indicated that they were supported to improve the security and safety of their home and when asked to explain the difference the support had made to their life, service users noted the impact of the service on their sense of security and safety. Reference was made to feeling 'less afraid', more safe living in a high crime area and more secure living in accommodation suitable to their needs.

*"The support has helped me feel safe & secure whilst being supported to find my own home."* (Service User Feedback)

*"It has been good having someone to talk things over and give advice, my support worker made a huge difference to me during the lockdown and ensured I received community support regarding food parcel and deliveries. I also have received security lighting and locks as I live alone and in a high crime area it has given me peace of mind when I go to bed."* (Service User Feedback)

*"I am now housed in a more suitable apartment which is wheelchair accessible, and it has helped me adapt to losing my limb more easily."* (Service User Feedback)

*Without the support I have had I wouldn't be living in the home I am now with my young family. I was supported to make my home safe and comfortable for myself and my young children through accessing benefits that have helped enable me to get me things such as carpet, wooden flooring, paint etc. as well as sourcing appliances that I needed for my home too such as cooker, fridge freezer and other appliances. I really appreciated the support my housing support worker has given me. It has helped me realise that I can manage a home on my own, so it has helped my confidence a lot.* (Service User Feedback)

### 5.2.5 Contribute to society and enhance social networks

For the period of the scope of this study, SP providers across all primary client groups reported that they successfully supported 27,454 service users out of 31,178 (88%) to improve or enhance their social network and make a positive contribution to society. This includes engaging/re-engaging with family or friends, participating in hobbies/activities (walking, sports, arts and crafts, cooking, gardening) etc.

95% of providers who responded to the survey identified that their SP funded service delivered improved social connectivity for their client group while 62% of service users who responded to the survey indicated that they were supported to improve their access to services and activities within their local community.

*"Before lockdown FS took me to appointments & helped me speak to Dr when I was afraid to. In times of real bad stress there is always someone at end of phone to listen to me & support me. When I was struggling financially FS brought food parcels for me & made referrals to social supermarket. Since lockdown has started, they've been there checking in with me & keeping me company on the phone & doorstep visits. Just having that connection & interaction has meant I haven't been so lonely."*

*'Having this service has made me feel so much more supported and less alone. I know there's somebody there to assist me with some of the things I struggle with like managing bills, appointments, and other things''.*

### 5.2.6 Crisis Accomodation Service Users

Crisis accommodation services provide accommodation to people experiencing temporary or ongoing conditions of crisis, with the aim of removing them from an otherwise harmful environment and allowing them to improve their situations from a safe and stable environment. Situations that may be alleviated through crisis accommodation include but are not limited to homelessness, domestic violence, and people living with alcohol or drug problems.

For the period of the scope of this study, SP providers (see table 7) reported that they successfully supported 622 service users out of 4,404 (14%) to move on from the crisis service into temporary living arrangements, 1,178 service users out of 4,351 (27%) to access healthcare whilst in a crisis accommodation service and 394 service users out of 394 (100%) to feel they could positively engage with the service, resulting in them feeling more secure and protected.

### 5.2.7 Service User Case Study 1

Service User A is a female aged 18-25 who resides in the Fermanagh and Omagh District Council area. She shared her experience of the Slate Project, an organisation funded through Supporting People:

*"I first got involved with the Slate Project about three years ago. At the time, I was living in rented accommodation with my ex and when we broke up, the rent payments got too much. I was close to being kicked out and becoming homeless. I reached out to First Housing, and we had a meeting about my circumstances. After they reviewed my circumstances, they referred me to the Slate Project. My support worker and the other staff within the Slate Project have been very helpful and supportive. They helped me to get a temporary flat for two years and from there they have supported me to get long term private accommodation.*

*I really struggle with my mental health, so I am also accessing floating support through the Slate Project. My support worker calls out once per week to talk to me, see how I am doing and if I need help with anything. They helped me to do a budget plan to make sure my bills always get paid; they did health and safety checks on the flat when I lived there, and they also referred me on to counselling to help me manage my mental health. They also helped me complete the application for housing benefit for my new place, this is something that I tried to do before but found really stressful, confusing, and difficult to complete. It was great they could help. I would not change anything about the service. It has been amazing and helped me a lot. I would definitely recommend it to anyone who was in a similar situation to me."*

### 5.2.8 Service User Case Study 2

Service User B is a male aged 36-45 who resides in the Derry City and Strabane District Council area. He shared his experience of receiving support through First Housing, an organisation funded by Supporting People:

*"I first accessed support from First Housing when I moved into supported living. Before this, I was living in more intensive supported living with carers etc because of my mental health. First Housing staff keep in contact and check in to see if I have any troubles. During lockdown, they called every couple of weeks for a catch up, a cup of tea and to see if I am managing okay. Before lockdown, there were always people trying to break into my apartment so First Housing put me in contact with Insight Co Security and this has helped me to feel safer.*

*First Housing have also helped me to complete forms to get benefits like ESA (Employment Support Allowance), health care forms and any other forms that come through my door. They go to all the right people which saves me the time and hassle. This really takes a lot of stress off me and works towards a better mental state. They also helped me to get my vaccine booked.*

*I do not have many friends so the people at First Housing are the only people I can really get support from. If I did not access support from First Housing I would have been stuck. They introduced me to the apartment that I am living in now and got me set up. I couldn't have sorted this out myself."*

### 5.2.9 Service User Case Study 3

Service User C is a male aged 66-75 who resides in the Newry, Mourne & Down District Council area. He has been a tenant in Housing Executive accommodation for ten years and has been in receipt of a floating support service for the past eighteen months and also receives domiciliary care support. His health has deteriorated, and he attends hospital in Belfast for regular treatments and check-ups.

*"I have no family or support structures locally and the SP service helps me with a lot of day-to-day stuff like managing money, keeping on top of my appointments, helping me to respond to benefit renewals and making sure that repairs/maintenance are carried out. I also have carers coming in, but they have their care tasks while the SP staff are there to support me with any problems that I have day to day. They really help me to be as independent as possible which makes me feel good about myself.*

*My health has got worse over the past couple of years, and I have to go for regular treatments and check-ups, the SP staff are always reminding me about appointments and make sure that I know what to bring with me. They are also very supportive as I do get worried before appointments, and it is great to have someone to talk to. They helped me recently to get a social alarm which is monitored, and this has helped my wellbeing as I feel more safe and secure. They give me tips on healthy eating and this helps me to keep my weight in check.*

*I really do not know what I would do without the SP staff, they have supported me through very difficult times and have been the difference between being able to stay in my own place and maybe having to go into a home. I am not as anxious about stuff like benefits and appointments as I used to be as I know that the staff are there to support me. Sometimes all I need is a person to talk to and explain things to me, it sounds simple but having someone checking in with me every day makes a big difference to my life".*

### 5.2.10 Service User Case Study 4

Service User D is a female aged 18-25 who resides in the Derry City and Strabane District Council area. She is a single mum of two children and shared her experience of the SATH Project, an organisation funded through Supporting People that provides a temporary accommodation solution and support package to those experiencing or at risk of homelessness. She accessed SATH temporary accommodation for nearly two years and has recently moved into a Housing Executive flat.

"*When I had my first child, I lived at home with my mother and siblings, and this worked well for a while, and they were a good support network for me, but it was a crowded space, and I knew I could not live there long term. When I became pregnant again, I began looking for alternative living arrangements and I got in touch with the Housing Executive who referred me to SATH.*

*It was a very difficult time for me when I moved into SATH as my oldest was aged 2 and my youngest was just a few months old but I was determined to live independently. The support was brilliant, I got advice with benefits, and they helped me to complete various forms. As I had moved out of the family home, I had no other support and the SATH staff were life changing for me. They organised some counselling which was just what I needed at the time.*

*I felt safe and secure which is very important when you have a young family. SATH got me in touch with SureStart and I started to attend their centre. They had a family support worker who helped me with mother and baby nurturing such as bottle feeding. I also did a parenting programme at SureStart which definitely improved my parenting skills. It also introduced me to other parents of my age and circumstances which was very helpful. I would not have found out about SureStart but for SATH".*

*I became much more independent through SATH and after nearly two years I was ready to move to full independent living and I have recently moved into a Housing Executive flat where I have my own tenancy. I no longer need any support and look forward to creating a new home for my children. When I look back on it, I cannot believe my progress and I have to give lots of thanks to the SATH staff who were absolutely fantastic for me".*

## 5.3 SP Providers

During the co-production process in late 2020 involving five web-based co-design workshops with 34 SP provider organisations from across all thematic groups, attendees identified the outcome themes to be included in the SP provider web-based survey. This survey was distributed to all providers in January 2021 and provided the opportunity to quantify the incidence of outcomes to facilitate the SROI calculations.

40 out of 86 service provider organisations responded to a web-based survey. When asked if their SP funded service delivered any outcomes for their organisation, 79% of respondents indicated that it improved their organisation's quality of services while 68% of respondents indicated that it improved their reputation.

86% of SP providers who responded to the survey indicated that their SP funded service delivered improved sustainability for them, 71% indicated that it improved their organisation's diversity of services, 64% identified that it improved their organisation's client reach while 43% indicated it improved their organisation's geographical reach. 46% of SP providers who responded to the survey indicated that their SP funded service improved their organisation's innovation and 25% identified that it improved their organisation's capacity to access additional funding.

This SROI study will use the above evidence as indicators of improved reputation and improved sustainability for providers and it is these outcomes that will be valued by assigning a financial proxy.

## 5.4 Health & Social Care

In-depth interviews were undertaken with a range of professionals from the Department of Health, Health & Social Care Board, Public Health Agency, and Health & Social Care Trusts who are also members of the four regional thematic groups (Older People, Mental Health & Disability, Homeless and Young People). Providing choice and options for meaningful independent living for each thematic group is the key priority for members. The subsequent sub sections explore the perspectives of the stakeholders on the impact and outcomes accrued from SP.

### 5.4.1 Avoidance/Deferral of Residential Care Costs

The older peoples programme starts at age 55+, though it was highlighted that the majority of people in this age profile group won't experience need for supported living until age 70 plus. Contributors referenced the pathway to mitigate against entry to residential or nursing care as people get older which can include downsizing, sheltered housing and domiciliary care. This ensures that older people still have a place *"they can identify as home with their own front door and can come and go as they please".*

One of the major impacts of the SP programme cited for older people has been the development of specialist services for people with dementia. It was highlighted that at the inception of the SP programme in 2003, there was limited awareness of dementia and as this has increased over the years so too has the capacity of providers to tailor housing and support solutions. "*There have been great outcomes for people with dementia achieved through an integrated funding model including SP".*

It was acknowledged that while most with end stage dementia will require residential care at some point, the time necessitated in this environment is greatly reduced as a consequence of the support funded by the SP programme. *"In the past people with dementia could be in residential care for between 5-10 years, now it is more likely to be 1-2 years".*

With people living longer, the incidence of diagnosed and undiagnosed mental health illness will expedite so the need for innovative independent living solutions will continue to intensify. To be responsive, planning is required. "*People with dementia and other diagnosed mental health issues are a growing population and provision needs to be planned for this cohort*".

The frail elderly client group are characterised by physical rather than cognitive impairments and access to SP support in addition to domiciliary packages has significantly increased the length of time this client group can live independently. *"Without SP the alternative would be care homes, unsuitable especially for younger generation. SP has helped to change the approach to how we care for and support older people without the requirement for individuals to be in a care home setting".* The need for more sheltered housing provision for the frail elderly was highlighted.

### 5.4.2 Reduced Healthcare costs

There was a consensus among all contributors that the outcomes accrued by the primary client groups accessing SP interventions reduced health related costs emanating from hospitalisations and treatment for substance misuse. In many such cases, there will be a dual diagnosis of addiction with mental health, with which SP also support clients.

People who have been or are at risk of homelessness are supported to improve their capacity to sustain stable tenancies. With a fixed address to register for health and social services, they are facilitated to access GP and Dentistry to improve their self-care which reduces the risk of emergency A&E and long stay hospitalisation at a future point.

The emergency Health and Social Care and Housing costs associated with Women at Risk of domestic violence are reduced through SP funded Women's Aid supports.

### 5.4.3 Mental Health & Disability

Mental Health & Disability accounts for 42% of the annual SP budget allocation and this thematic group works across all ages. The reform of Adult Social Care is the key policy framework underpinning work in this area. All of the teams in the Department of Health (Nursing Homes, Domiciliary Care, Older People, Physical & Sensory Disability & Mental Health) work closely with SP.

There is a dedicated team with the DoH for the resettlement of people with severe learning difficulties from Muckamore hospital. SP has been an enabler in this resettlement programme working closely with domiciliary care providers to ensure the appropriate balance between support and care is available for the service user to transition to and sustain independent living.

While the complexity of need for some Muckamore resettlements require intensive packages of support that in some cases may be as costly as residential care, the value of facilitating independent living and the person's right to access same is the critical factor for the resettlement team. Contributors welcomed the focus on valuing the outcomes for the person accessing independent living in addition to the cost implications of service delivery models.

Professionals working in the learning disability area referenced the high proportion of younger people with a learning disability who live with their parents and pointed to the need for effective planning as parents get older and their capacity to support and care is reduced. SP have a pivotal role in funding transitional models of support where young people move into independent living, and acquire the skills necessary to sustain it, through support from SP.

The positive work that SP has undertaken with parents of those resettled from Muckamore and those with learning difficulties who have moved out of the family home was heralded. Parents can be naturally anxious about their child with a learning difficulty moving out and prior consultation and on-going engagement with parents is a critical part of the transition process. The flexibility of floating support which is attached to the person regardless of their living environment was also highlighted as a key enabler for independent living. This can include support to access day care or further education and training opportunities.

The right of people regardless of race, religion or disability to independent living is championed by the Patient Client Council. SP is a crucial enabler for people to exercise this right through their housing related support but additionally through supporting day opportunities, employability, education, training, and social outreach.

### 5.4.4 Young People Leaving Care

The population of looked after children is increasing and the demand for suitable accommodation services for this cohort when they reach 18 and exit the care system is growing. There is insufficient capacity currently in the system to meet such demand. Where such accommodation is available through jointly commissioned services, the outcomes for the young people have been positive with many rekindling relationships with family and friends and progressing in education, training, or employment. This increased capacity and independence can divert from the Justice System and reduce their dependence of the Health & Social Care system in later life.

*"SP facilitates a successful transition to housing/ independent living among a very vulnerable group, good outcomes for much less investment than the alternatives. Possibly run too lean in terms of overall costs".*

## 5.5 Justice

The subsequent sub sections explore the perspectives from professionals in the Department of Justice on the impact and outcomes accrued from SP.

### 5.5.1 Reduced Offending

SP funds the support provided within the seven Approved Premises (APs) in Northern Ireland which are residential units housing ex-offenders in the community. Contributors highlighted the impact of the APs, both in terms of their contribution to the public protection arrangements in Northern Ireland, and in providing support for the rehabilitation of offenders. Criminal Justice Inspection Northern Ireland (CJINI) inspections have also found that offenders reduce their risk levels of reoffending while living in APs[15].

There are 92 places in APs across Northern Ireland. SP funds the key worker who works with the AP resident on their rehabilitation and resettlement pathway with the expectation that they will be able to transition to full unsupervised independent living within 12 months[16]. This can include engaging with landlords who may be reluctant to offer a tenancy post AP discharge. Capacity permitting, the Northern Ireland Prison Service would use APs as part of their temporary release programme to prepare those coming to the end of life sentences to reintegrate into the community.

The impact of SP on the risk indicators for offending was highlighted: stable accommodation and mental health in addition to reduced or abstinent drug and alcohol use can significantly reduce the risk of offending. Particular concern was expressed about young women and their accommodation needs when in the justice system. There is currently only one mixed gender hostel for access on release from custody for females and there is a tangible fear among victims about perpetrators of sexual abuse being released from prison. Women may also not be granted bail due to lack of accommodation and may spend their remand in prison.

Availability of qualified staff is paramount when managing offenders, especially in the approved premises, and the contribution of SP funding towards staffing costs is crucial for their recruitment and retention. Stable accommodation is one of the main contributors to desistence and with SP supporting the reintegration of prisoners into the community, the risk of re-offending is reduced. Demand for accommodation for those coming out of the justice system is very high, and there are pressures on the system; the Reducing Offending Unit are working collaboratively with SP and housing providers to identify innovative ways to free up capacity in the system.

[15] Layout 1 (cjini.org)
[16] The maximum period of stay in the AP is two years.

### 5.5.2 Young People Leaving Custody

Contributors noted that prior to SP, young people who were preparing to leave custody were not properly supported, and were often placed in Bed & Breakfast or Hotels temporarily until suitable accommodation could be sourced. In some cases, young people were not eligible to leave custody due to their homeless status. Young people in custody have many different needs such as mental health, low educational attainment, poor family support or substance misuse. Young people in unstable accommodation find it difficult to focus on other areas of their life such as employment, education, and mental health. Through SP, they can focus on these other areas of their development which can make them less reliant on Health & Social Services in later life.

## 5.6 Housing

The impact of SP on housing stakeholders was discussed through in-depth interviews with NIHE Senior Management and Board, and housing association staff who engaged in the co-production workshops. The subsequent sub sections explore the perspectives of same stakeholders.

### 5.6.1 Integrated Model

Participants reflected on the journey of progression that SP has facilitated from pre-2003, when all housing management and support costs were paid through Housing Benefit – which was unsustainable.

*"SP enabled the integration of care, support and housing in a relatively seamless way for the end user, it combines the needs of the person, and is very person centred".*

*"SP is a really effective way of joined up working across departments in NI; previously the mindset was insular and territorial. SP facilitated a mindset change across government departments; it is an NI wide approach that has brought solutions to some of the more vulnerable groups in society*".

### 5.6.2 Sustainable tenancies

One third of the current NIHE programme would cater for homelessness, with many commissioned SP projects for this cohort. One innovative example is the Stella Maris hostel in Belfast which caters for homeless people with alcohol addictions and operates on a 'harm reduction model' which encourages residents to reduce their alcohol intake alongside a plan of medical care, healthy eating, and activities such as art and gardening. This hostel represents significant savings against the time that rough sleepers with addictions might spend in hospital or presenting to A&E. It gives these people the chance to become tenancy ready.

The Interface between SP and Health is critical, *"Health services can deal with people with addictions when they are settled at a fixed address, SP workers can ensure they are registered with a GP and Dentist to enhance their self-care".*

The Housing Executive defines tenancy failure as a case where the tenancy is not sustained for at least one year. A tenancy breakdown is very costly for the NIHE: the longer the tenancy continues, the better value the NIHE get with maintenance and overheads. If a vulnerable individual can live independently and sustain their tenancy, there will be a reduced need for crisis interventions.

The 2015 DSD Review of SP found that the Floating Support Model plays a key role in early intervention and prevention. This support can mitigate against the onset of more serious and profound health and well-being issues in the future, enabling individuals to sustain and maintain tenancies. The benefits accrued from Floating Support interventions are brought to life by the case studies in Section 5.2.

## 5.7 Communities

In-depth interviews were undertaken with professionals from the Department for Communities (DfC). Housing responsibilities under DfC include social housing, advice and guidance for all tenures, and housing policy and legislation. Much of its work in relation to housing is led by the NIHE. Fostering vibrant sustainable communities is one of the high-level outcomes that the NIHE seek to deliver on, and the efficacy of this outcome is co-dependent on the extent to which the other three NIHE high level outcomes (Helping people find housing support and solutions; Delivering better homes; Delivering quality public services) are achieved.

Tackling disadvantage and promoting equality of opportunity by reducing poverty, promoting, and protecting the interests of children and young people, older people, people with disabilities, and other socially excluded groups and addressing inequality and disadvantage are key strategic priorities for the DfC. SP funding is channelled towards 15 primary client groups who have some level of vulnerability, requiring additional supports to live independently.

All of the service user outcomes documented and discussed in Section 5.2 contribute to more cohesive communities and active citizenship but are valued for the service user as they experience the change first hand. To also value such outcomes for the community would be double counting. However, we must acknowledge the impact of service user outcomes for the communities in which they reside and the SROI calculation results in Section 6 provide DfC with a robust vindication of their funding of the SP programme.

# Section 6: Calculating the SROI

## 6.1 Introduction

Having identified and categorised the stakeholders, and the outcomes most relevant for each, this section calculates the SROI through the application of materiality, estimation of proxy costs, and consideration of deadweight, displacement, attribution, drop off and discounting.

## 6.2 Materiality

In line with guidelines for conducting SROI analysis, an outcome was defined as material when:

- it was relevant to and consistent with the scope of the study
- it was significant in that it could influence decisions and inform good practice and, critically,
- it could be evidenced.

Throughout the stakeholder engagement, we sought to collate evidence for the desired outcomes as per the SP programme stakeholder analysis in Section 4.

We found that the desired outcomes pertaining to the Health Professionals and the Health Sector in relation to: reduced caseloads and stress, improved access to supports, reduced costs, improved efficiencies, and public perception, while material, could not yet be robustly evidenced to merit valuation. Table 4 presents the outcomes that are valued as part of the SROI calculation. The impact map in appendix 1 illustrates the outcomes valued for each stakeholder group and the number (%) within each stakeholder group that benefitted from this outcome.

## 6.3 Monetisation

This SROI study seeks to transparently calculate the value of changes effected by the SP programme. It does this by using the metric of value that we are all accustomed to: money. This 'monetisation' process does not mean that the figures that are represented such as savings in healthcare costs are redistributed; rather, attempts have been made to equate the value that stakeholders place on certain impacts achieved through SP funding to other things to which they attach importance.

The total amount invested by DfC over the 2.5-year scope of this study was £182 million which was agreed with NIHE as the final input figure. For each stakeholder outcome, the cost of an alternative activity that would have led to the same outcome (a proxy cost), was selected through

discussion between the evaluation team and stakeholders and with reference to research evidence. The objective in proxy selection was to identify the best available alternative approach to achieving a similar outcome.

A robust proxy requires evidence of effectiveness and of cost and must be recognised as a realistic activity for stakeholders to undertake. We used a combination of data sources for the proxy estimation including the HACT Social Value Bank and the costs associated with services and interventions to achieve similar outcomes sourced from desk review and experiential learning. For example, cost of GP appointment, Accident and Emergency attendance, counselling, imprisonment etc. To further validate proxy selection, stakeholders were asked to place a value on several outcomes. Appendix 2 sets out a full explanation of the financial proxies used.

## 6.4 Calculating Impact

The total sum of outcomes and associated financial proxies equals £1,925,333,962 (See appendix 2). In order to calculate the SROI ratio, deadweight, displacement, attribution and drop off were considered for each of the outcomes achieved.

### 6.4.1 Deadweight

The assessment of deadweight is framed around the question: '*What would have happened anyway?'* In order to estimate the percentage of the outcome that would be achieved in the absence of SP, discussions on alternative activities available to participating stakeholders were facilitated.

In the absence of SP, there is a high likelihood that those in the primary client groups would not have had the capacity to access services available to enhance their independence. Additionally, with reducing budgets available to Health & Social Care and the Department of Justice, it is unlikely that resources to support independent living to the extent that the SP programme has, would have been made available.

SP providers reported an increasing trend of having to provide "holding supports, in many cases from their own resources, to stabilise those with mental health and addiction issues as they awaited assessment or interventions from specialist services. This amplifies the dearth of alternative services available for SP clients with complex support needs and increases their dependency on SP support.

With due consideration of the internal capacity of SP clients and the external funding environment, Deadweight has been assigned at relatively low levels (<=20%) for the discounting of service user outcomes. When applying deadweight to the HSCT, Justice and Housing stakeholders, we were cognisant of the sheer scale of the agencies concerned. It is therefore likely that in the absence of SP funding, the existing staffing infrastructure of HSCT, PBNI and the NIHE would divert a proportion of people from residential care, hospitalisation and the custodial sentences thus achieving some element of cost savings which we factor in at a level of 10-35%.

### 6.4.2 Displacement

Displacement relates to the question: '*Were there any activities with the same outcome displaced by the interventions of SP?*' Contributors agreed that there was no displacement of other activities arising from SP supports in accommodation based or floating support services. The absence of equivalent services to those funded by SP across Northern Ireland evidence limited displacement (0-10%)

### 6.4.3 Attribution

Attribution speaks to the question: *'Who else contributed to the achievement of the outcome?'* Table 9 sets out the attribution rates assigned to each stakeholder outcome group.

| Stakeholder | Attribution |
|---|---|
| Service User Outcomes | 20% |
| SP Providers | 25% |
| Health & Social Care Trust | 10%-35% |
| Department for Justice | 35% |
| NIHE | 25% |

**Table 9: Attribution**

Given the vulnerability of the primary client groups, there is a greater likelihood that family support systems may not be in place, hence any assumption that family or other support networks might have delivered similar support in the absence of SP is not cogent. Attribution has therefore been assigned at relatively low levels (<=20%) for the discounting of service user outcomes.

SP providers include some of the largest housing associations and social care providers in Northern Ireland and with innovation and the multi-faceted skill set of their staff incorporating care and support, we conclude that attribution for their outcomes of improved sustainability and enhanced reputation is appropriate at the level of 25%.

Outcomes accruing to Health & Social Care Trusts (HSCT) and the Department of Justice relating to reduced costs have been discounted at levels in the range of 10% to 35% to reflect the intensive support that is provided on a case management basis by HSCT and Probation Board NI staff to support independent living in the community and reduced offending. Similarly with the status of the NIHE as the largest landlord in Northern Ireland, we must acknowledge the role of their skilled and specialist staff in facilitating sustained tenancies which negate the costs associated with breakdown or failed tenancies.

### 6.4.4 Duration

Duration refers to how long (in years) each of the outcomes last after the intervention. Outcomes at 1 are considered to have a low duration i.e., without the intervention it is unlikely that the outcome will be sustained, while outcomes at 6 are considered to have a long duration. A summary of the outcomes and projected duration is provided below.

| Outcome | Duration |
|---|---|
| Improved access to benefits | 4 |
| Improved employment (paid/voluntary) | 4 |
| Improved access to training/ education | 6 |
| Improved independent living | 3 |
| Improved management of physical and mental health | 2 |
| More secure in own home | 2 |
| Contribute more to society and social networks | 1 |
| Alternative temp living arrangements -crisis | 1 |
| Supported access to healthcare | 1 |
| More secure and protected | 1 |
| Improved reputation | 2 |
| Improved sustainability | 2 |
| Reduced costs – all stakeholders | 2 |

Table 10: Duration of Outcomes

### 6.4.4 Drop-off

A drop-off value was used for each outcome to account for the diminishing value of the outcome over time. For example, in the case of improved access to benefits it is highly possible that once a service user has been supported to access benefits they will continue to avail of such benefits post intervention. Therefore, the subsequent drop-off is low. Similarly, knowledge gained from access to education and training is a lifelong outcome with a low drop-off rate. Comparatively, crisis accommodation services are more short term in nature and therefore the drop-off rate is high.

Once deadweight, displacement, attribution and drop-off were considered, the total social value was estimated as £1,069,163,012. Tables 11 and 12 provide an overview of this total value per stakeholder group and primary client group. [17]

| Stakeholder | Social value £ | % of Total Value |
|---|---|---|
| Service Users | £550,529,318.20 | **51.50%** |
| SP Provider | £683,142.19 | **0.06%** |
| Health and Social Care Trust | £485,862,458.10 | **45.44%** |
| Department for Justice | £12,548,250.00 | **1.17%** |
| NIHE | £19,539,843.75 | **1.83%** |
| **Total** | **£1,069,163,012.24** | **100.00%** |

**Table 11: Social Value by Stakeholder**

| Stakeholder | Social value £ | % of Total Value |
|---|---|---|
| Frail Elderly | £5,097,040.99 | **0.93%** |
| Homeless Families with Support Needs | £48,048,845.06 | **8.73%** |
| Offenders or people at risk of offending | £8,723,599.40 | **1.58%** |
| Older people with mental health problems/dementia | £9,648,021.46 | **1.75%** |
| Older people with support needs | £163,661,974.80 | **29.73%** |
| People with physical or sensory disability | £15,218,980.73 | **2.76%** |
| People with alcohol problems | £40,300,269.96 | **7.32%** |
| People with drug problems | £2,021,655.35 | **0.37%** |
| People with learning disabilities | £52,914,189.68 | **9.61%** |
| People with mental health problems | £47,402,030.17 | **8.61%** |
| Single Homeless with Support Needs | £79,740,121.87 | **14.48%** |
| Traveller | £659,900.93 | **0.12%** |
| Women at risk of domestic violence | £55,471,424.72 | **10.08%** |
| Young people | £19,879,277.59 | **3.61%** |
| Single Homeless crisis accommodation | £1,741,985.48 | **0.32%** |
| Total | £550,529,318.20 | **100%** |

**Table 12: Social value per primary client group**

[17] Social Value per stakeholder reflects value prior to application of discounting per year at 3.5%.

Table 12 shows that Older People with support needs are the primary client group for which SP has created most value. Financial proxies were applied consistently across all primary client groups except for the value placed on access to benefits (informed by current benefit rates for each primary client group) and access to employment and education.

Older People with support needs represented 28% of the total number of service users who achieved benefits, 29% of the total service users who achieved improved physical and mental health, 40% of the total service users who felt more safe and secure and 42% of the overall service users who achieved independent living. The main differentiator in value calculation was therefore the quantity of older people with support needs who were reported as achieving outcomes. (See section 6.5)

### 6.4.4 Discounting

To calculate the net present value (NPV) the costs and benefits paid or received in different time periods need to be added up. In order that these costs and benefits are comparable a process called discounting is used. Discounting recognises that people generally prefer to receive money today rather than tomorrow because there is a risk (e.g., that the money will not be paid) or because there is an opportunity cost (e.g., potential gains from investing the money elsewhere). This is known as the 'time value of money'. There is a range of different rates for discounting; however, for the public sector, the basic rate recommended in HM Treasury's Green Book is 3.5%. Based on a discounting rate at 3.5% the total net present value is therefore £1,038,786,036.

| Years | Total Value | Total Present Value |
|---|---|---|
| Year 0 | 485,514,608.79 | 485,514,608.79 |
| Year 1 | 365,530,833.48 | 353,169,887.42 |
| Year 2 | 115,345,861.00 | 107,676,595.49 |
| Year 3 | 96,812,660.05 | 87,319,472.55 |
| Year 4 | 2,990,010.15 | 2,605,621.10 |
| Year 5 | 2,969,038.73 | 2,499,850.94 |
| **Totals** | **1,069,163,012.65** | **1,038,786,036.29** |

**Table 13: Net Present Value**

## 6.5 SROI Results

This SROI study has applied financial proxies and associated attribution, deadweight, displacement, drop off and discounting to 119 outcomes for five material stakeholder groups.

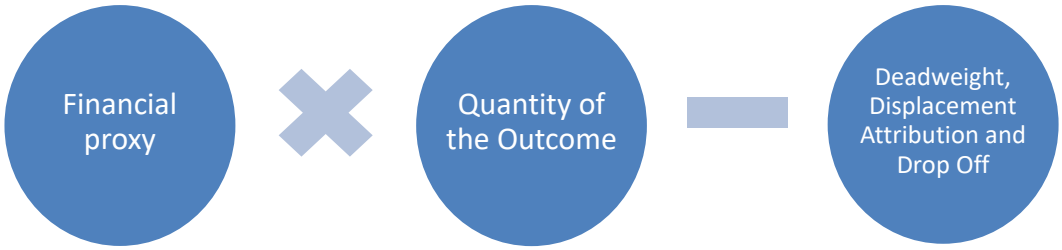



**Figure 3: Calculating the SROI**

To calculate the Social Return on Investment for Supporting People, the Total Present Value of £1,038,786,036 was divided by the total input figure of £182,000,000. The Supporting People Programme over the two-and-a-half-year period 2018 to the first two quarters of 2020/21 generated a social value of £1: £5.71.

We ran sensitivity analysis to test the sensitivity of changes in the assumptions made for the calculations. The inputs are fixed on the basis that they represent the audited spend on the SP programme over the duration of the scope of the study, hence there is no rationale for testing the sensitivity of changed inputs. The numbers in each of the primary client groups are derived directly from the SP reporting system, hence no estimation on the quantity of stakeholders was needed.

When the attribution for the highest value proxy of reduced costs (HSCT) is decreased from 35% to 10%, the SROI ratio changes from 5.71 to 6.7 and when deadweight is increased from 30% to 50% the SROI ratio changes from 5.71 to 4.98. While somewhat sensitive, this falls within the threshold for sensitivity (+or- 25%). The proxies relating to the valuation of reduced healthcare costs (residential care, treatment for drug & alcohol, GP appointments, counselling, attendance at Accident & Emergency) have been sourced from accredited sources.

In conclusion, the ratio of £1: £5.71 has been arrived at through the meticulous application of the principles of SROI and we believe it is a fair and consistent illustration of the social value generated by the SP programme.

# Section 7: Discussion & Learning

## 7.1 Introduction

This section discusses and summarises the SROI study and reflects on key learnings, challenges, and areas for improvement.

## 7.2 Summary of SROI Results

The Supporting People Programme over the two-and-a-half-year period 2018 to the first two quarters of 2020/21 generated a social value of £1: £5.71. This is based on a Total Present Value of £1,038,786,036.30 created against the input of £182,000,000. This is a positive finding for both the NIHE and DfC, and it confirms the conviction that was a recurring theme in the stakeholder consultation, that the change delivered by the SP programme has considerable worth for a wide range of stakeholders. The distribution of value across health, housing, justice and community is the manifestation of the cross-cutting vision for SP at its inception in 2003.

As illustrated in Section 5, Table 6, 25,164 SP service users benefitted from improved access to welfare benefits, 9,085 gained employment, while 31,687 benefitted from improved independent living. 27,365 service users better managed their physical and mental health, 33,153 felt more secure in their home/tenancy and 27,454 were supported to contribute to society and social networks. 1,178 service users who accessed crisis accommodation services gained access to healthcare, 622 gained access to alternative temporary living arrangements and 394 benefitted from feeling secure and protected.

The social value created for SP service users accounts for 51.5% of the total social value created. Therefore, in social value terms, SP service users are the primary stakeholder. This resonates with the person-centred philosophy of SP, which places the service user as the main benefactor of the intervention. It also addresses the deficit of evidence pertaining to the value of "soft outcomes" such as independence, and well-being which has traditionally been challenging for service providers and funders.

Of the 86 providers, 75% benefitted from improved reputation and 26% benefitted from improved sustainability. The social value created for this stakeholder group accounts for 0.06% of the total value calculated.

The value generated for the HSCTs represents the second highest proportion of the total social value created by SP (45.44%) The vast majority of the SP client group will have some interface with HSC. The SP programme provides a mechanism for collaboration between HSC and SP to support the most vulnerable people in society, which reduces the burden on the HSC budget and delivers better value for the public purse. Building the capacity of the SP service user to maintain independent living is a preventative measure and builds resilience to the escalation of health and wellbeing issues for the primary client groups.

The value created for NIHE accounts for 1.83% while the value created for the Department of Justice represents 1.17%.

The findings from this study suggest that investment in the Supporting People programme generates important value and cost savings for multiple stakeholders. Ongoing investment in this type of programming is likely to advance the achievement of positive outcomes and generate social value throughout communities.

Providers consulted as part of this study expressed the need to segment the value per primary client group. By doing so, providers can identify evidence of the social value that their work with specific primary client groups accrues. This can inform a framework for social value measurement that providers can implement across their organisation/service in the future. Additionally, members of the thematic groups can demonstrate the value for their primary groups which can strengthen their lobby for the investment of additional resources.

## 7.3 Strategic Alignment

Our review of the strategic positioning of the SP programme found the cross-cutting contribution of the SP programme to the new PfG, with a clear concentration on outcomes relating to: *healthy lives*, *feeling safe* and *a caring society that supports people throughout their lives*. This resonates with the original aims and objectives of SP. There appears a stronger alignment between SP and the nine outcomes in the new PfG than to the 14 outcomes and 42 indicators in the preceding PfG, reinforcing the strategic position of the SP programme.

Our findings augment those from the 2015 Strategic Review of the SP programme which concluded that "*the Supporting People programme has achieved its core aims, delivering significant quality of life benefits to those who have received services, assisting the resettlement of people from institutional settings and preventing problems which could have led to hospitalisation, institutional care or homelessness*". This SROI study quantifies such resettlement and values the preventative actions.

Furthermore, the 2015 Strategic Review found that *"Supporting People services prevented crime and, more significantly in financial terms, reduced pressure on health and social care budgets*". It also unearthed a significant body of qualitative evidence on the positive difference the programme has made to the lives of many people. With the data from the SP outcomes reporting framework commencing April 2018 and the application of SROI principles, this study has quantified and valued the difference SP is making to people's lives.

## 7.4 Quality of Inputs

Almost 90% of the SP providers operate within the charitable, voluntary, or housing association sectors. Contributors highlighted the highly skilled and competent staff resource that providers offer, which facilitates a person-centred approach and wrap-around support to meet the complex needs of the various primary client groups. Quality is maintained despite no incremental pay increases for staff and static non-inflationary SP payments for providers in recent years. Providers have demonstrated agility in response to emerging need and in cases where SP funding is insufficient to meet the client need, providers will use other organisational resources to ensure continuity of provision.

## 7.5 Jointly Commissioned Services

While the process for commissioning services can be complex, the SP programme is most effectively utilised where there are jointly commissioned services to meet the needs of the primary client groups. The increased number of specialist supported housing projects for people with dementia is an exemplar of a collaborative approach involving SP, NIHE, HSCTs, providers, service users and their families. There are other notable examples for people with a physical disability, for people coming out of prison, for young people leaving the care system and young homeless. Contributors emphasised the importance of all stakeholders working towards a shared vision with common goals and regular communication.

## 7.5 Challenges

This section explores some of the key challenges identified for Supporting People.

### 7.5.1 Funding

As of 2019/2020, SP grant funds 86 delivery partners that provide over 850 housing support services for to up to 19,000 service users across Northern Ireland. While the budget for the SP Programme in Northern Ireland increased from £46 million in 2003/04 to £72.8 million in 2014, it has remained static ever since. Typically, grant funding agreements are renewed annually with service providers, usually at the same rate as previous years. This does not account for inflation or minimum wage increases.

This creates significant challenges for SP providers and in some instances has necessitated the use of other organisational resources or reserves to ensure continuity of service. In the absence of a funding uplift, providers face growing pressure to reduce costs without impacting quality or access to services. Therefore, increasing demand and a greater complexity of need among SP primary client groups has caused greater case/workloads among SP provider staff and has thus created significant challenges for providers in terms of the recruitment and retention of high calibre, trained staff.

### 7.5.2 Need & Demand

70% of providers who responded to the provider survey identified that their clients had additional support needs that could not be met through SP funding. Some of these included: assistance with personal care, medication, befriending, shopping, food poverty and fuel poverty as well as the trauma experienced by children who become homeless as a result of domestic violence and family breakdown.

SP providers also reported a shortage in supply of suitable accommodation for various primary client groups including young people leaving care and an increasing trend of having to provide “holding supports”, in many cases from their own resources, to stabilise those with mental health and addiction issues as they awaited assessment or interventions from specialist services. They noted that the complex needs of service users often extend beyond the two-year support duration of SP Floating Support service and that alternative services are inaccessible or unavailable due to lengthy waiting lists, location, travel etc, thus increasing their dependency on SP support.

The increasing housing and health needs resulting from the COVID-19 pandemic were also identified as a considerable challenge for SP providers. SP service users already experience a range of vulnerabilities regarding mental ill health, abuse, addiction, and disability and while the full effects of the pandemic are yet to be known, there is evidence of job losses, loss of income, increased loneliness, isolation, and emotional stress as well as increased risk of domestic violence among some of the most marginalised members of society. This will significantly increase the needs of SP's target client groups and the subsequent demand for SP services.

### 7.5.3 Staffing

SP operates a person-centred philosophy, enabling people who use services to plan their own futures and to get the services that they need. Staff are a key resource for making person-centred planning possible. Sufficient staff who are suitably qualified, trained and supported are needed to support the implementation of person-centred planning, especially for those service users with particularly complex needs.

High caseloads among SP provider staff coupled with inconsistent pay levels has created significant challenges for providers in terms of staff burnout, high levels of staff turnover and the ability to successfully recruit and retain high calibre, trained staff. Furthermore, it was noted that there exists a lack of a career pathway for staff delivering SP interventions, resulting in SP being used as a 'stepping-stone' for nursing careers, for example.

## 7.6 Area for Improvement

This section explores some of the key areas of improvement for Supporting People:

### 7.6.1 Collaboration

Although existing multi-agency collaboration and cooperation was identified as effective, contributors emphasised the importance of fostering relationships among stakeholders at both a regional and local level. While the thematic groups represent a positive mechanism for enabling cross sector partnerships, contributors noted that there is room for improvement and that local interagency collaboration has potentially been lost. Establishing appropriate structures to facilitate joined up working at a local level, between statutory, community and voluntary organisations across health, housing, justice, education and law enforcement may enable a more co-ordinated and integrated approach to meeting the complex needs of SP's client groups. The community planning process facilitated by the local Councils across the 11 council areas represents an exemplar model for this.

### 7.6.2 Service Delivery Consistency

While the existing design and model for SP in terms of enabling collaboration and joint commissioning of services between SP, Northern Ireland Housing Executive and the Department of Health has been endorsed, challenges regarding consistency in service delivery and quality assurance have been identified.

SP providers vary in staffing models deployed such as staff structure, personal development requirements, staff support and pay, as well as overall ethos, policies, and guidelines. While many jointly commissioned services are regulated by the Regulation and Quality Improvement Authority (RQIA),[18] this level of quality assurance does not extend to services providing SP support only and does not include all jointly commissioned services.

To guarantee consistent achievement of outcomes for service users, a standardised best practice approach for quality assurance, integrating the RQIA process and the SP Quality Monitoring Tool represents a key area of improvement for SP. This would augment the current SP and RQIA Memorandum of Understanding relating to services which are assessed by both, which was a recommendation from the Ministerial review of SP in 2015.

[18] RQIA is an independent body responsible for monitoring and inspecting the availability and quality of health and social care services in Northern Ireland and encouraging improvements in the quality of those services.

### 7.6.3 Outcomes Framework

Since April 2018, providers of Supporting People (SP) services have been required to collect and submit outcome data. While this data has been useful for evidencing and valuing the outcomes delivered by SP and the subsequent social value created for each of the 15 primary client groups, the existing SP Outcomes Framework could be refined to enable a more definitive statement of value created by SP, that can be used and updated to track value creation over time.

For example, the outcomes data collected through the SP Outcomes System combines mental and physical health improvements as an indicator of Being Healthy. While this does reflect an indicator of Being Healthy, differentiating the number supported to achieve improvements in mental health outcomes from those who achieved improvements in physical health would enable a more robust and accurate representation of the value accrued for the service users under this outcome.

Similarly, the SP Outcomes System combines paid/voluntary employment and training/education as an indicator of Economic Wellbeing. Therefore, it was not clear as to the number in each primary client group who achieved employment versus those who accessed education, and thus assigning an appropriate financial proxy was assumption based. In measuring the value of this outcome, reporting separately on such indicators to allow for the economic benefit/value of service users gaining employment or accessing education/training to be more accurately captured represents an area of improvement.

### 7.6.4 Stakeholder Outcomes

The SP Outcomes Framework sets out a range of high-level programme outcomes aligned to outcome indicators and service level outcome measures to capture the difference that its intervention is making to the lives of service users. It does not explore the change created for stakeholders other than the service users.

This SROI study has identified that SP delivers outcomes for multiple stakeholders including SP Providers, Health and Social Care Trust, Department of Justice and Northern Ireland Housing Executive. It has also identified other material stakeholders who are impacted by SP, including service user families and the Department for Communities. Although value for all stakeholders could not be evidenced in this study, SP could improve the existing Outcomes Framework to better reflect additional stakeholders and desired outcomes of same.

# Section 8: Recommendations

## 8.1 Introduction

The following recommendations are offered for consideration.

## 8.2 Embedding SROI

A positive ratio of 1: 5.71 has been evidenced through this study. We would recommend that Supporting People continue on their journey of impact measurement by further embedding SROI principles and data collection in the evaluation of their work. Further to the area for improvement identified in 7.6.3, It is recommended that SP consider revising the existing model for data collection so that providers can report on indicators separately e.g., physical health and mental health. This will enable a more accurate statement of the value created by SP.

A critical part of the embedding process is understanding who the organisation's stakeholders are and devising a mechanism to effectively engage with them. The stakeholder analysis and resultant consultation for this study has captured a more diverse range of stakeholders than is currently illustrated in the SP Outcomes Framework. We recommend that this be augmented to reflect the additional stakeholders (Department of Justice, SP Providers, Health and Social Care Trust, Department for Communities and Service User families) and their desired outcomes.

To value the change for this expanded and diverse stakeholder group, it is recommended that SP consider building on existing data collection processes so that outcomes for all material stakeholders can be evidenced and valued. This should include the identification of indicators for improved family relationships, more cohesive and resilient communities, and enhanced community safety; for example, a reduction in the number of rough sleepers in areas that SP services operate as well as a reduction in anti-social behaviour.

## 8.3 Dissemination

To showcase the impact of the SP programme, the NIHE should disseminate the results of this study widely both internally and externally through the mediums of succinct infographics with links to the full report and impact map. The findings should also be optimised to position DfC in their annual bids to the Department of Finance for additional resources. It is reasonable to assume that any future additional resources invested in SP would at a minimum generate social value aligned to the ratio return of £1: £5.71 calculated for the duration of this study.

## 8.4 Floating Support

The 2015 DSD Review of SP found that the Floating Support Model plays a key role in early intervention and prevention and highlighted the potential to extend SP services geographically, particularly across rural areas. Based on these findings, the review recommended that the NIHE should actively progress opportunities to expand the floating support service as a cost-effective way of meeting need.

Despite this recommendation, the 2019-20 split for SP funded services is 84% for accommodation-based services and 16% for floating support services. Floating support services deliver strong preventative benefits to people in the community in a very cost-effective way. This support, which follows the individual, can mitigate against the onset of more serious and profound health and well-being issues in the future. It can also provide greater access to services for people living in rural and remote areas. The benefits accrued from floating support interventions are brought to life by the case studies in Section 5.2.

We recommend that future planning of SP services consider how to increase the funding allocation to floating support to make it a more prominent element of the overall programme. One potential area of development to be explored should be floating support for young people.

## 8.5 Provider & Service User Involvement

The SP contract managers provide the main access point for engagement with providers and this conduit is used to involve providers in relevant research and service reviews. The client reference group has provided a forum for service providers to input into the strategic needs assessment framework and this has been well received by providers. In relation to end service user engagement, this is led by the service provider and the policies that are in place for service user involvement with no direct channel between the end user and the NIHE.

We recommend that NIHE consider the development of a service user policy which stipulates the mechanisms that they use to ensure that the voice of service users is prominent in the monitoring and review of existing services and the commissioning of new services. This should include seeking increased service user representation on the regional thematic group across all four areas.

## 8.6 Future Research

While the current study begins to shed light on the value of supports for SP service users and material stakeholders, more rigorous research on the impacts of SP services is needed to help develop deeper and more robust understanding of impact, particularly long-term impact. It is recommended that opportunities for future research on the subject are pursued to advance the knowledge and information available about SP interventions for the different primary client groups.

Resources permitting, we would recommend a longitudinal study to track a sample from each primary client group who have exited SP services for a maximum period of three years. This study should measure the extent to which the outcomes achieved per primary client group sample were sustained, for example, improvements to mental and physical health, improved independent living and improved economic wellbeing. This would facilitate a more robust analysis of the duration of outcomes achieved for each of the Primary Client Groups.

## Appendix 1: SP Outcomes Framework

| | | | | | Applicable to Client Group | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Draft PfG Target(s)** | **SP Programme - High Level Outcome** | **SP Services - Outcome Indicators** | | **Service Level Outcome Measure** | **MH & Disability** | **Older People** | **Homeless** | **Young People** | **Crisis Accommodation Services** |
| We care for others and help those in need | 1. Improved Economic Well-being for service users | 1a. Service users supported to access welfare benefits | | Number of service users in receipt of any relevant benefits as a result of the support provided | √ | √ | √ | √ | X |
| More people working in better jobs | | 1b. Service users supported to gain employment (paid or voluntary) and/or enhance skills / education | | Number of service users who engaged in employment (paid or voluntary) and/or desired training/education as a result of support provided | √ | √ | √ | √ | X |
| We care for others and help those in need | 2. Increased number of people living Independently | 2a. Service users supported to remain in own home **(LONG TERM SERVICES ONLY)** | | Number of Service users in a sustained tenancy 12 months after start of support service | √ | √ | √ | √ | X |
| | | 2b. Service users supported to achieve independent living **(SHORT TERM SERVICES ONLY)** | | Number of service users living in permanent/ stable accommodation in the community as a result of support provided | √ | X | √ | √ | X |
| | | 2c. Number of service users supported to move into alternative temporary living arrangements **(CRISIS ACCOMMODATION SERVICES ONLY)** | | Number of service users successfully moved into alternative temporary living arrangements as a result of support provided | X | X | X | X | √ |
| | | 2d. Service users supported to maintain their tenancy as a result of floating support **(FLOATING SUPPORT SERVICES ONLY)** | | Number of service users who maintained their tenancy as a result of floating support being provided | √ | √ | √ | √ | X |
| We care for others and help those in need | 3. Being Healthy | 3a. Service users supported to manage their physical / mental health | | Number of service users who accessed primary health care / mental health services / social services as a result of support provided | √ | √ | √ | √ | X |
| We enjoy long, healthy, active lives | | 3b. Number of service users supported to access healthcare **(CRISIS ACCOMMODATION SERVICES ONLY)** | | Number of service users who accessed healthcare as a result of support provided | X | X | X | X | √ |
| We care for others and help those in need | 4. Living in Safety & Security | 4a. Number of service users who have been supported to feel secure in own home/tenancy | | Number of service users feeling more secure as a result of support provided | √ | √ | √ | √ | X |
| We have a safe community where we respect the law and each other | | 4b. Number of service users who have been supported to feel secure and protected **(CRISIS ACCOMMODATION SERVICES ONLY)** | | Number of service users feeling secure and protected as a result of support provided by service | X | X | X | X | √ |
| We enjoy long, healthy, active lives | 5. Achieving & making a Positive Contribution | 5a. Service users supported to contribute to wider society and enhance social networks | | Number of service users who have improved /enhanced their social network as a result of support provided (e.g. improve family relationships; participating in community projects/residents groups/ volunteering etc.) | √ | √ | √ | √ | X |

## Appendix 2: Impact Map

| Stakeholder | Outcome | Qty | Proxy | Value £ | Proxy Value |
|---|---|---|---|---|---|
| **Service Users** | Improved access to benefits | 25,164 | Range of benefits – breakdown below | | £577,654,962.00 |
| Frail elderly & older people with support needs | Improved access to benefits | 7,159 | Old Age Pension (£134.25 x 52 = £6,981 GOV UK) | £6,981.00 | £486,675,979.00 |
| People with physical or sensory disability, alcohol problems, drug problems, learning disability, mental health problems | Improved access to benefits | 5,676 | Disability Living Allowance - £151 per week x 52 weeks = £7,852 | £7,852.00 | £44,567,952.00 |
| Homeless families with support needs | Improved access to benefits | 2,011 | £324.84 per month for single claimants aged 25 or over, £282.50 per month first child<br>= £7,288 per year | £7,288.00 | £14,656,168.00 |
| Offenders, single homeless, traveller, women at risk of domestic violence | Improved access to benefits | 9,091 | £291 (average of single claimants over and under 25) = £3,493 per year | £3,493.00 | £31,754,863.00 |
| Young people | Improved access to benefits | 1,227 | Standard universal credit limit is £257.33 per month for single claimants under 25 x 12months | £3,087.96 | £3,788,926.92 |
| Service Users | Gained paid employment. | 2,134 | Full time employment - £14,433 (Social Value Bank) | £14,433.00 | £30,800,022.00 |

| Stakeholder | Outcome | Qty | Proxy | Value £ | Proxy Value |
|---|---|---|---|---|---|
| Service Users | Gained Voluntary employment | 2,132 | Regular volunteering - £3,249 (Social Value Bank) | £3,249.00 | £6,926,868.00 |
| Service Users | Access to training/ education | 4,726 | Vocational training - £1,124 (Social Value Bank) | £1,124.00 | £5,312,024.00 |
| Service Users | Improved independent living | 31,687 | Housing services that provide assistance to secure or maintain housing (Social Value Bank UK £193) | £193.00 | £6,115,591.00 |
| Service Users | Better manage physical and mental health | 27,365 | Community Counselling Cost £20 per session x 4 sessions per month = £120 Gym membership = £30 per month =£150 per month x 12 months | £1,800.00 | £49,257,000.00 |
| Service Users | More secure in own home | 33,153 | Home Security System - £500 | £500.00 | £16,576,500.00 |
| Service Users | Improved contribution to society and social networks | 27,454 | Member of social group (Social Value Bank) £1,850 per year | £1,850.00 | £50,789,900.00 |
| Crisis Service Users | Alternative temporary living arrangements | 622 | Average cost of overnight stay in Belfast x 7 days | £558.00 | £347,076.00 |
| Crisis Service Users | Access Healthcare (crisis) | 1,178 | Community Counselling Cost £20 per session x 4 sessions per month = £120 Gym membership = £30 per month =£150 per month x 12 months | £1,800.00 | £2,120,400.00 |
| Crisis Service Users | Secure & Protected (crisis) | 394 | Home Security System - £500 | £500.00 | £197,000.00 |
| SP Provider | Improved reputation | 65 | ISO 9001 Certification | £695.00 | £45,175.00 |
| SP Provider | Improved sustainability | 22 | Average amount of additional funding sourced by providers as a result of SP – Reported in SP Provider survey | £ 53,150.00 | £1,169,300.00 |

| Stakeholder | Outcome | Qty | Proxy | Value £ | Proxy Value |
|---|---|---|---|---|---|
| Health and Social Care Trust | Avoidance of residential care costs | 14,222 | Cost of residential care, £704 per week, £36,608 per year | £36,608.00 | £520,638,976.00 |
| Health and Social Care Trust | Reduced health care costs | 1,869 | £265 per day x average 4 weeks admittance | £7,420.00 | £13,867,980.00 |
| Health and Social Care Trust | Reduced health care costs | 3,517 | Cost of counselling x 8 sessions | £800.00 | £2,813,600.00 |
| Health and Social Care Trust | Reduced health care costs | 15,593 | Cost of at least 1 GP Appointment to NHS | £30.00 | £467,790.00 |
| Health and Social Care Trust | Reduced health care costs | 6,211 | Cost of at least 1 A&E Attendance to NHS | £419.00 | £2,602,409.00 |
| Department for Justice | Reduced costs | 390 | Cost of prison stay - £55,000 per year in NI (average) | £55,000.00 | £21,450,000.00 |
| NIHE | Reduced costs | 9,925 | Cost of failed tenancy reported by NIHE as £3,500 | £3,500.00 | £34,737,500.00 |

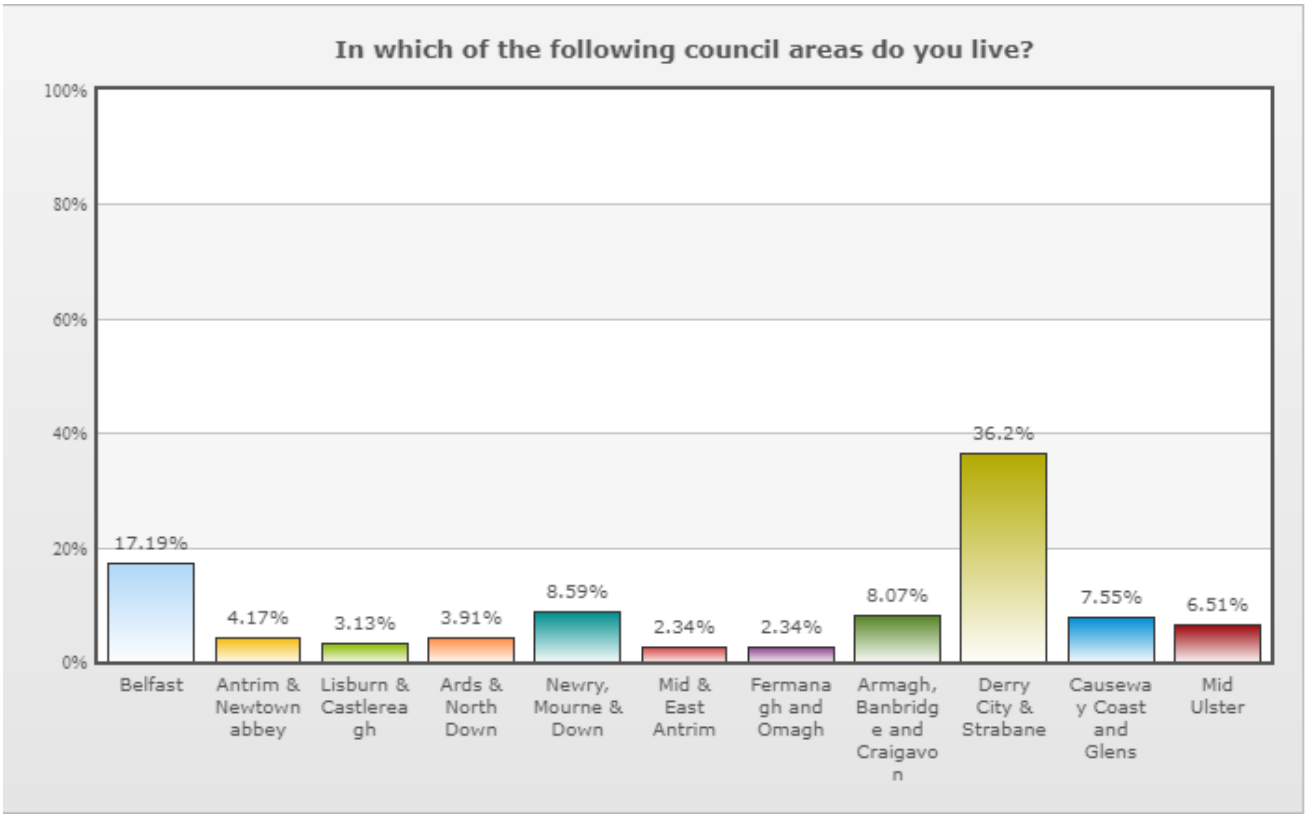
**Table 14: Application of financial proxies prior to application of deadweight, attribution, displacement, discounting.**

## Appendix 3: Knowledge Based Assumptions

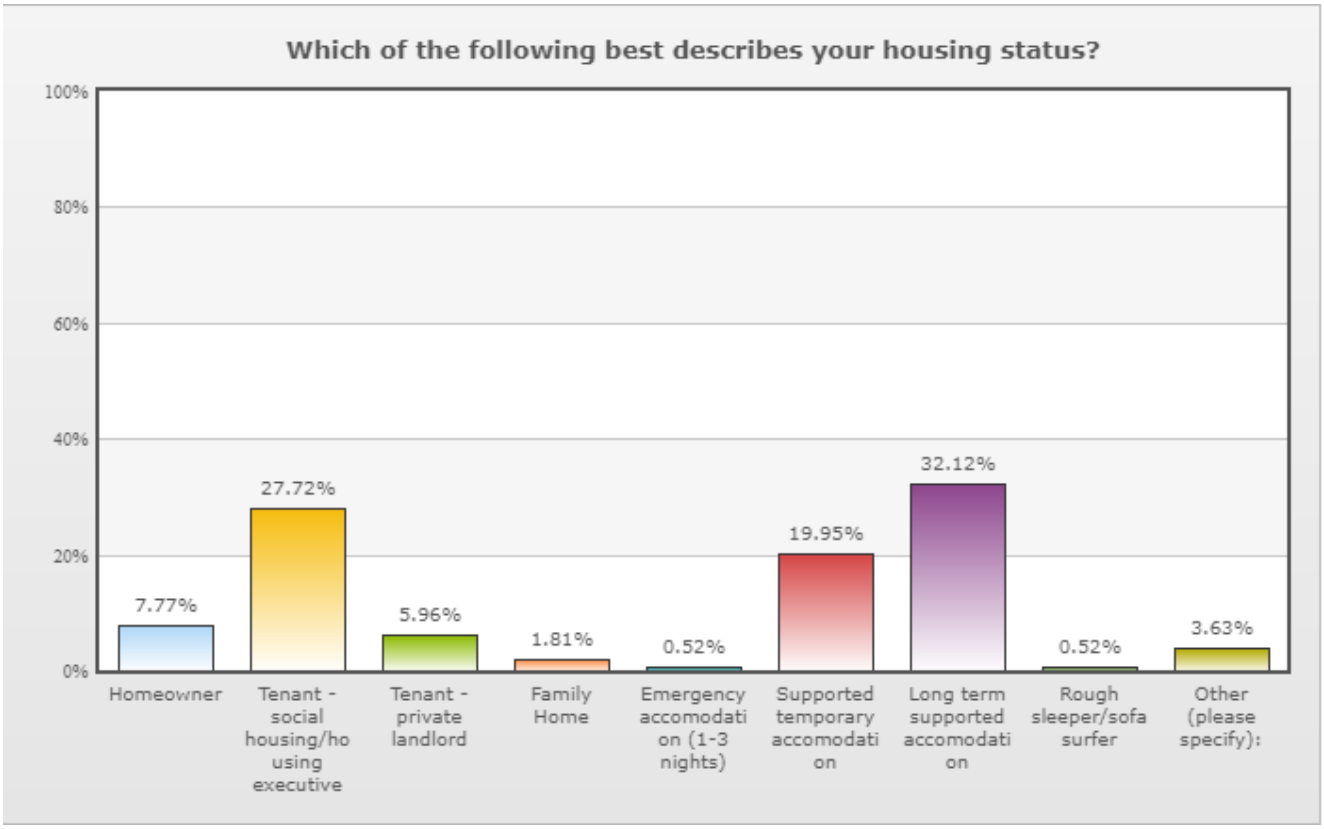
| Section of Report | Assumption | Explanation |
|---|---|---|
| Evidencing & Valuing Outcomes: Gain Employment (paid or voluntary) and/or desired training/education | Frail elderly, older people with support needs and mental health problems were supported to access education training not paid or voluntary employment. | The outcomes data collected through the SP Outcomes System does not differentiate the number in each client group who were supported to achieve employment, paid or voluntary. It is unlikely that this client group entered into paid or voluntary employment due to SP and therefore it was assumed that all in this primary client group accessed training/education. |
| Evidencing & Valuing Outcomes: Gain Employment (paid or voluntary) and/or desired training/education | The % of all other primary client groups accessing paid or voluntary employment was less than those accessing training or education. | The outcomes data collected through the SP Outcomes System does not differentiate the number in each client group who were supported to achieve employment, paid or voluntary or access training/education. |
| Evidencing & Valuing Outcomes: Independent Living | Maintaining tenancy and remaining in own home are indicators of independent living. | The outcomes data collected through the SP Outcomes System rates each of these three indicators. However, to avoid double counting, they were combined under one outcome for valuing. |
| Evidencing & Valuing Outcomes: Managing physical and mental health | Both mental and physical health was improved for all primary client groups | The outcomes data collected through the SP Outcomes System does not differentiate the number in each client group who improved mental health and the number who improved physical health. |
| Evidencing & Valuing Outcomes: Health & Social Care Trust - Avoidance of Residential costs | Once a client group are supported to access residential care, they remain there for 2+ years therefore a 0% drop off rate was applied to residential care cost savings for HSCT. | Applying a 0% drop off rate to this outcome enabled the outcome to be valued for a period of 2 years. |

# Appendix 4: Profile of Service User Survey Respondents

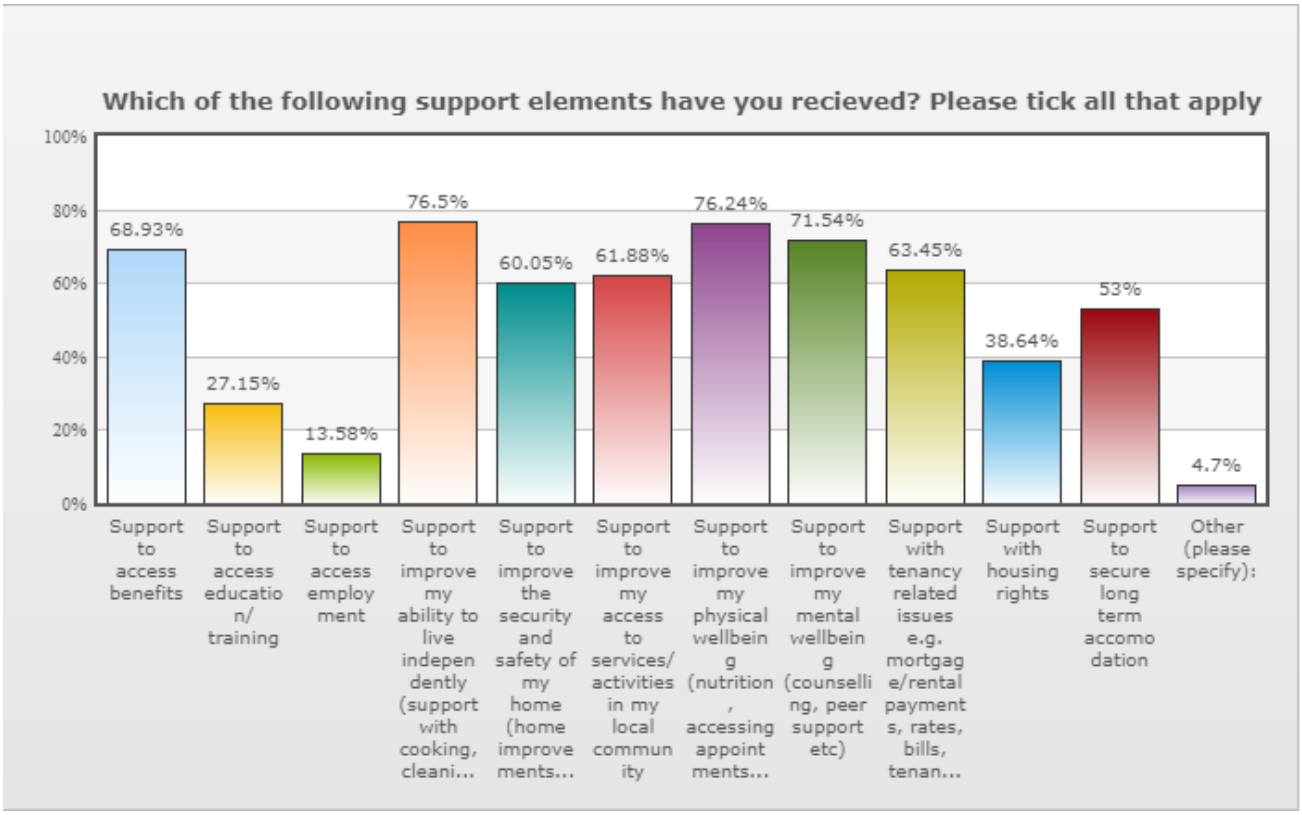
- 391 responses
- 51% male and 49% female
- 16% of respondents were aged under 25, 47% were aged 26-65 while 37% were aged 66+.
- 54% of respondents indicated that they had a disability while 46% indicated they did not.
- 36% of respondents indicated that they lived in Derry City and Strabane, 17% lived in Belfast and 9% in Newry, Mourne and Down.



- 32% of respondents were in long term supported accommodation, 28% were in social housing/Housing Executive tenants while 20% indicated their housing status was supported temporary accommodation.



76% of respondents indicated that they received support to improve their ability to live independently and their physical wellbeing, 72% identified they received support to improve their mental wellbeing and 68% indicated they received support to access benefits.




69% of respondents indicated the support they received was very effective and 27% indicated it was effective.